

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

129357

12941

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Carroll		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westminster		c. LENGTH OF STAY IN 1b 2wks	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) x2 Rural--Westminster		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Ibex Nursing Home			d. STREET ADDRESS Spring Mills Rd.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) EMMA First COOK Middle BARNES Last			4. DATE OF DEATH Month DEC. Day 11 Year 1957		
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-12-1868		9. AGE (In years last birthday) 89 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY home	11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME John W. Cook			14. MOTHER'S MAIDEN NAME Mary Shipley		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) none	17. INFORMANT William A. Barnes, Address Same		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral hemorrhage DUE TO Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (b) _____ DUE TO (c) _____					INTERVAL BETWEEN ONSET AND DEATH 5 mos. 10 + yrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Jan 1947 to Dec 11, 1957 , that I last saw the deceased alive on Dec 11, 1957 , and that death occurred at 8 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 15 Kemper Ave Westminster DATE SIGNED 12-16-57					
ACTUAL SIGNATURE Dr Reese Wilkens M.D. 15 Kemper Ave Westminster					
PHYSICIAN'S NAME (Type) Dr Reese Wilkens					
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 12-14-1957	22c. NAME OF CEMETERY OR CREMATORY Sams Creek Brethren		22d. LOCATION (City, town, or county) (State) Carroll Co., Maryland
23. FUNERAL DIRECTOR'S SIGNATURE C. M. Waltz,			ADDRESS Winfield, Md.		
24a. RECEIVED BY REGISTRAR DEC 16 1957			24b. REGISTRAR'S SIGNATURE Harriet Muller		

CERTIFICATE OF DEATH

BUREAU V. 2

DEC 16 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12941 CERTIFICATE OF DEATH

12936

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>CARROLL</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>CARROLL</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL WESTMINSTER</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WESTMINSTER</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>579 BALTO. BLVD.</u>		d. STREET ADDRESS <u>266 E. MAIN</u>	
3. NAME OF DECEASED (Type or print) First <u>RACHAEL</u> Middle <u>MARTHA</u> Last <u>BEAVER</u>		4. DATE OF DEATH Month <u>12</u> Day <u>21</u> Year <u>1957</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JULY 7 1864</u>
9. AGE (In years last birthday) <u>93</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>MD.</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>JESSE BEAVER</u>		14. MOTHER'S MAIDEN NAME <u>SARAH HOOK</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>MRS MILTON ENSON</u>		Address <u>579 Balto Blvd WESTMINSTER, MD.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ARTERIO-SCLEROTIC C-V. DISEASE</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH <u>YEARS.</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21. I certify that I attended the deceased from <u>Dec 21</u> , 19 <u>57</u> , to <u>Dec 21</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Dec 21</u> , 19 <u>57</u> , and that death occurred at <u>4 P M</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>James J. Marsh</u> M.D.		DATE SIGNED <u>105 E Main St</u>	
PHYSICIAN'S NAME (Type) <u>JAMES J. MARSH</u>		<u>Westminster MD</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>12-24-57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>WESTMINSTER CEM.</u>	22d. LOCATION (City, town, or county) (State) <u>WESTMINSTER MD.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>David G. Bankard Westminster, Md.</u>		24a. REC'D BY REGISTRAR <u>David G. Bankard</u> 24b. REGISTRAR'S SIGNATURE <u>Harriet Miller</u>	

REC 30 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE OF MARYLAND DEPARTMENT OF HEALTH—BALTIMORE, 18

12945

CERTIFICATE OF DEATH

12937

Reg. Dist. No.

94

1. PLACE OF DEATH a. COUNTY Carroll b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville c. LENGTH OF STAY IN 1b since 10/26/55 d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore City (Zone 18) c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore City (Zone 18) d. STREET ADDRESS 1360 Homestead St. 812 Regester Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) First Middle Last Arthur Frederick Beck				4. DATE OF DEATH Month Day Year December 18 19 57											
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 4-30-92		9. AGE (In years last birthday) 65		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerical Worker				10b. KIND OF BUSINESS OR INDUSTRY - - - - -				11. BIRTHPLACE (State or foreign country) Maryland				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Frederick Beck						14. MOTHER'S MAIDEN NAME Ann (Maiden name unknown)									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. 705-05-3039		17. INFORMANT Address Records of Springfield State Hospital									
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia 491X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic brain syndrome associated with other diseases of unknown or uncertain cause, with psychotic reaction.										INTERVAL BETWEEN ONSET AND DEATH 4 days					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)										20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) - - - - -					
20c. TIME OF INJURY Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) - - - - -		20f. (City or town) - - - - -		(County) - - - - -		(State) - - - - -			
21. I certify that I attended the deceased from October 26, 1955 , to December 18, 1957 , that I last saw the deceased alive on December 18, 1957 , and that death occurred at 9:30 P.M. , from the causes and on the date stated above.															
ACTUAL SIGNATURE Martin Gross						ADDRESS (Street, city or town, state) Springfield State Hosp. Sykesville, Maryland						DATE SIGNED 12-19-57			
PHYSICIAN'S NAME (Type) Martin Gross, M.D.															
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 12/23/57		22c. NAME OF CEMETERY OR CREMATORY Cathedral Cmn				22d. LOCATION (City, town, or county) (State) Baltimore Md.					
23. FUNERAL DIRECTOR'S SIGNATURE J. Melville Jenkins						ADDRESS 2713 Park ave		24a. REC'D BY REGISTRAR DATE 23 1957		24b. REGISTRAR'S SIGNATURE C.H. Weir					

BUREAU V. S.

DEC 28 1961

RECEIVED

12946

CERTIFICATE OF DEATH

Reg. Dist. No.

76

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Finksburg</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Finksburg, Md</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Ced Finksburg Road</u>		d. STREET ADDRESS <u>Ced Finksburg Rd 1</u>	
3. NAME OF DECEASED (Type or print) First <u>Amonda</u> Middle <u>Wullette</u> Last <u>BLACK</u>		4. DATE OF DEATH Month <u>December</u> Day <u>20</u> Year <u>1957</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JUNE 7, 1880</u>
9. AGE (In years last birthday) <u>77</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>NONE</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>DAVID A. Abbott</u>		14. MOTHER'S MAIDEN NAME <u>Lucinda ?</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>HARRY BLACK</u>		Address <u>Finksburg, Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of face (nose)</u> 191X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO (c) <u> </u>			INTERVAL BETWEEN ONSET AND DEATH <u>14 yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. <u> </u> p. m. <u> </u> 19 <u> </u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>June 1953</u> to <u>Dec 20 1957</u> , that I last saw the deceased alive on <u>Dec 19 1957</u> , and that death occurred at <u>9:07 a.m.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>M. C. Porterfield</u> M.D.		ADDRESS (Street, city or town, state) <u>Hampstead, Md</u>	
PHYSICIAN'S NAME (Type) <u>M. C. Porterfield, M.D.</u>		DATE SIGNED <u>12-20-57</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>12/23/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Finksburg Methodist</u>	22d. LOCATION (City, town, or county) (State) <u>Finksburg, Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. E. Myers, J. Westmanster, Md</u>		24a. REC'D BY REGISTRAR DATE <u>12-21-57</u>	
24b. REGISTRAR'S SIGNATURE <u>H. G. Miller</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
BM 2/57

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
12947 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12939

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Carroll b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) rural Westminster c. LENGTH OF STAY IN life life d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) near Leister's Church		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE Maryland b. COUNTY Carroll c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) rural Westminster d. STREET ADDRESS near Leister's Church e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) HARVEY DANIEL BREITWEISER First Middle Last 4. DATE OF DEATH 12 9 1957 Month Day Year		5. SEX Male 6. COLOR OR RACE White 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH Mar 18-91 9. AGE (In years last birthday) 66 yrs. 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farm hand 11. BIRTHPLACE (State or foreign country) Carroll County, Md. 12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME John L. Breitweiser		14. MOTHER'S MAIDEN NAME Minerva Garrett	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 220-34-6682 17. INFORMANT Mrs. Charles Brehm Address Westminster, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Coronary occlusion DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH min.		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE James T. Marsh EXAMINER'S NAME (Type) James T. Marsh, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12-12-57	
22c. NAME OF CEMETERY OR CREMATORY Westminster Cemetery		22d. LOCATION (City, town, or county) (State) Westminster, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE John R. Byers ADDRESS Westminster, Maryland		24a. REC'D BY REGISTRAR DATE Dec 11 1957 24b. REGISTRAR'S SIGNATURE Harold Smith	

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 19
1957 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. 2

DEC 16 1957

RECEIVED

12948

CERTIFICATE OF DEATH

Reg. Dist. No.

74

1. PLACE OF DEATH o. COUNTY Cannoll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore City 13 3001-4			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital				d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Wilhelmina Catherine Brenner				4. DATE OF DEATH Month December Day 25 Year 1957			
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-29-1863	9. AGE (In years lost birthday) 94 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William Ritterputsch				14. MOTHER'S MAIDEN NAME Elizabeth Klingelhoefer			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none		17. INFORMANT Springfield State Hospital		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Cardiovascular Disease months (c) Generalized Arteriosclerosis years						INTERVAL BETWEEN ONSET AND DEATH minutes	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. CBS ass with disturbance of metabolism, growth or nutrition with senile brain disease with psychotic reaction						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Jan 22 , 19 53 , to Dec 25 , 19 57 , that I last saw the deceased alive on Dec 24 , 19 57 , and that death occurred at 9:30 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Springfield State Hospital DATE SIGNED ACTUAL SIGNATURE Elizabeth Kuopp M.D. Sykesville, Maryland PHYSICIAN'S NAME (Type) Elizabeth Kuopp							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/27/57		22c. NAME OF CEMETERY OR CREMATORY Oaklawn Cem.		22d. LOCATION (City, town, or county) (State) Balto. Co., Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Wm G. Schuer & Sons - Balt.				24a. REC'D BY REGISTRAR DATE 2/26/57		24b. REGISTRAR'S SIGNATURE C. Harry Heery	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

DEC 27 1953

12949 CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Carroll</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Woodbine</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Woodbine X1</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Morgan Road</u>		e. STREET ADDRESS <u>Morgan Road</u>	
3. NAME OF DECEASED (Type or print) <u>Raymond Allan C. Burrier</u> First Middle Last		4. DATE OF DEATH <u>Dec 31 1957</u> Month Day Year	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 20, 1905</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Agriculture</u>	9. AGE (In years last birthday) <u>52</u> yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.
11. BIRTHPLACE (State or foreign country) <u>MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Joseph R. Burrier</u>		14. MOTHER'S MAIDEN NAME <u>Isabelle Allen</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) <u>-</u>		16. SOCIAL SECURITY NO. <u>213-10-7311</u>	
17. INFORMANT <u>Mrs Ada Burrier - Woodbine, Md</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac arrest, rheumatic heart disease</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cardiac failure, coronary thrombosis</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			INTERVAL BETWEEN ONSET AND DEATH <u>1957</u> to <u>Dec 1957</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>1954</u> , 19____, to <u>31 Dec 1957</u> , that I last saw the deceased alive on <u>31 Dec 1957</u> , and that death occurred at <u>5:00 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Howard E. Hall</u> M.D.		ADDRESS (Street, city or town, state) <u>Shesapeake, Md</u> DATE SIGNED <u>31 Dec 57</u>	
PHYSICIAN'S NAME (Type) <u>HOWARD E. HALL</u>		<u>SYKESVILLE, MD</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>1-3-58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Meadowridge</u>	22d. LOCATION (City, town, or county) (State) <u>Dorsey, Howard Co., Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur A. Knight</u> ADDRESS <u>Sykesville, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>1-1-58</u>	24b. REGISTRAR'S SIGNATURE <u>C. Harry Wice</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON, ONE

BUREAU V. S.

JAN 6 1939

RECEIVED

12950 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Howard			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Henryton				c. LENGTH OF STAY IN 1b 206 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Henryton State Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Rose Middle Bruce Last Carter				4. DATE OF DEATH Month December Day 13 Year 19 57			
5. SEX Female		6. COLOR OR RACE Negro		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9-26-1907	
9. AGE (In years last birthday) 50 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Clarksville, Maryland				12. CITIZEN OF WHAT COUNTRY? U. S. A.			
13. FATHER'S NAME William Bruce				14. MOTHER'S MAIDEN NAME Susan Smith			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Rose B. Carter-Patient			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiovascular insufficiency DUE TO (b) Diabetes DUE TO (c) Far advanced bilateral pulmonary TB CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST.						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 260X						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) Henryton, Maryland				20g. (County) Howard		20h. (State) Md	
21. I certify that I attended the deceased from May 20, 1957 , to Dec. 13, 1957 , that I last saw the deceased alive on Dec. 13, 1957 , and that death occurred at 11 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Dr. Edgar M. Maculans				DATE SIGNED 12-13-57			
PHYSICIAN'S NAME (Type) Dr. Edgars M. Maculans, Supt. Henryton State Hospital, Henryton, MD							
22a. BURIAL, CREMATION, REMOVAL (Specify) Buried		22b. DATE THEREOF 12/17/57		22c. NAME OF CEMETERY OR CREMATORY 1st Baptist Cemetery		22d. LOCATION (City, town, or county) (State) Guilford, Md	
23. FUNERAL DIRECTOR'S SIGNATURE Charles Harper				ADDRESS 512 Conventon rd		24a. REC'D BY REGISTRAR DATE 11-14-57	
24b. REGISTRAR'S SIGNATURE Albert R. Snowhauer							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12951 CERTIFICATE OF DEATH

12943

Reg. Dist. No. 74

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institutional Residence before admission) a. STATE Maryland b. COUNTY Balto. City	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN 1b 4 mos. 4 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Mary Middle Loretta Last CASSADY		4. DATE OF DEATH Month December Day 13 Year 57	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 8, 1891
9. AGE (In years last birthday) 66 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Secretary		10b. KIND OF BUSINESS OR INDUSTRY YAK	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John K. Cassady		14. MOTHER'S MAIDEN NAME Mary Loretta Mackin	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. -YAK	
17. INFORMANT Springfield Hospital Records		Address	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral hemorrhage		INTERVAL BETWEEN ONSET AND DEATH Hours
420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		Years
(b) Arteriosclerotic heart disease		Years
(c) Generalized arteriosclerosis		Years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) C.B.S. assoc. with circ. dist. with cerebral arteriosclerosis, with psychotic reaction, with severe diabetes.		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
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21. I certify that I attended the deceased from **Oct. 23, 1957**, to **Dec. 13, 1957**, that I last saw the deceased alive on **Dec. 13, 1957**, and that death occurred at **8:50A M.** from the causes and on the date stated above.

ADDRESS (Street, city or town, state) **Springfield State Hospital** DATE SIGNED **12/13/57**

ACTUAL SIGNATURE **Walther H. Sonnenfeldt** M.D.

PHYSICIAN'S NAME (Type) **Walther H. Sonnenfeldt, M.D.** **Sykesville, Maryland**

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 12-16-57	22c. NAME OF CEMETERY OR CREMATORY Holy Redeemer	22d. LOCATION (City, town, or county) (State) Baltimore, Md.
23. FUNERAL DIRECTOR'S SIGNATURE William Cook, Inc.		24a. REC'D BY REGISTRAR 12-13-57	24b. REGISTRAR'S SIGNATURE C. Harry Wiser

CERTIFICATE OF DEATH

Form No. 100-100

<p>1. NAME OF DECEASED [REDACTED]</p>		<p>2. SEX [REDACTED]</p>		<p>3. AGE [REDACTED]</p>		<p>4. DATE OF BIRTH [REDACTED]</p>	
<p>5. PLACE OF BIRTH [REDACTED]</p>		<p>6. OCCUPATION [REDACTED]</p>		<p>7. MARITAL STATUS [REDACTED]</p>		<p>8. EDUCATION [REDACTED]</p>	
<p>9. CAUSE OF DEATH [REDACTED]</p>		<p>10. MANNER OF DEATH [REDACTED]</p>		<p>11. PLACE OF DEATH [REDACTED]</p>		<p>12. DATE OF DEATH [REDACTED]</p>	
<p>13. SIGNATURE OF PHYSICIAN [REDACTED]</p>		<p>14. SIGNATURE OF REGISTRAR [REDACTED]</p>		<p>15. SIGNATURE OF WITNESS [REDACTED]</p>		<p>16. SIGNATURE OF DECEASED [REDACTED]</p>	

BUREAU V. 1

DEC 19 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 12944

12952

CERTIFICATE OF DEATH

Reg. Dist. No.

74

1. PLACE OF DEATH o. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE Maryland b. COUNTY Carroll			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville				c. LENGTH OF STAY IN 1b 1 Mo.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Emerald Drive				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First William Middle Herbert Last Close				4. DATE OF DEATH Month Dec. Day 24 Year 1957			
5. SEX M.	6. COLOR OR RACE W.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 29, 1884		9. AGE (In years last birthday) 73 yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Fireman.				10b. KIND OF BUSINESS OR INDUSTRY Balto. City		11. BIRTHPLACE (State or foreign country) Md.	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Robert Close				14. MOTHER'S MAIDEN NAME Martha Acton			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. 214-22-0829		17. INFORMANT MRS IANTHA BENTON, SYKESVILLE MD. Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.1 Cardio-Respiratory failure DUE TO (b) Myocardial degeneration & DUE TO (c) Chronic failure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Intussusception							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour o. m. p. m. 19	Month 12	Day 24	Year 1957	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan 26, 1956 , to 24 Dec, 1957 , that I last saw the deceased alive on 24 Dec. , 19 57 , and that death occurred at 2:00 PM , from the cause and on the date stated above.							
ACTUAL SIGNATURE William J. Bryson M.D.				ADDRESS (Street, city or town, state) 4605 Edmondson Ave Balto 24, Md DATE SIGNED 26 Dec 57			
PHYSICIAN'S NAME (Type) William J. Bryson							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Dec 28/57	22c. NAME OF CEMETERY OR CREMATORY Loudon Park Cem.		22d. LOCATION (City, town, or county) (State) Balto. Md.			
23. FUNERAL DIRECTOR'S SIGNATURE Witzke Funeral Dir. ADDRESS 4101 Edmondson Ave.				24a. REC'D BY REGISTRAR 12/27/57		24b. REGISTRAR'S SIGNATURE C. Harry Steery	

CERTIFICATE OF DEATH

Form 100-10

<p>1. NAME OF DECEASED</p> <p>2. SEX</p> <p>3. AGE</p> <p>4. DATE OF BIRTH</p> <p>5. PLACE OF BIRTH</p> <p>6. OCCUPATION</p> <p>7. MARITAL STATUS</p> <p>8. CAUSE OF DEATH</p> <p>9. PLACE OF DEATH</p> <p>10. DATE OF DEATH</p> <p>11. TIME OF DEATH</p> <p>12. SIGNATURE OF DECEASED</p> <p>13. SIGNATURE OF WITNESSES</p> <p>14. SIGNATURE OF PHYSICIAN</p> <p>15. SIGNATURE OF CORONER</p> <p>16. SIGNATURE OF JURY</p> <p>17. SIGNATURE OF JUDGE</p> <p>18. SIGNATURE OF CLERK</p> <p>19. SIGNATURE OF REGISTRAR</p> <p>20. SIGNATURE OF OFFICIAL</p>	
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BUREAU V. S.

DEC 30 1957

RECEIVED

12953 CERTIFICATE OF DEATH

12945

Reg. Dist. No. 81

1. PLACE OF DEATH o. COUNTY <u>CARROLL</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>CARROLL</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TANEY TOWN</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TANEY TOWN</u> x1			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>RURAL</u>				d. STREET ADDRESS <u>RURAL</u>			
3. NAME OF DECEASED (Type or print) <u>F. LEROY CROUSE</u>				4. DATE OF DEATH <u>DEC. 19 1954</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>DEC 18 - 1884</u>		9. AGE (In years last birthday) <u>73</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>INVALID</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>WILLIAM CROUSE</u>				14. MOTHER'S MAIDEN NAME <u>CATHERINE CLAPSADDLE</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT <u>ADDIE CRUMBACKER</u> Address <u>UNION BRIDGE</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> <u>331X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>clotting a</u> DUE TO (c) <u>clotting a</u>						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Dec 18 1954</u> to <u>Dec 18 1954</u> , that I last saw the deceased alive on <u>Dec 18 1954</u> , and that death occurred at <u>10:15 A.M.</u> from the cause and on the date stated above. ADDRESS (Street, city or town, state) <u>Union Bridge Md</u> DATE SIGNED <u>Dec 19 1954</u>							
ACTUAL SIGNATURE <u>J. H. MESSLER</u> M.D.				PHYSICIAN'S NAME (Type) <u>J. H. MESSLER M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>DEC 21 - 1954</u>		22c. NAME OF CEMETERY OR CREMATORY <u>MT UNION</u>		22d. LOCATION (City, town, or county) (State) <u>UNION BRIDGE RURAL MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. Hartzler & Sons</u> ADDRESS <u>Union Bridge, Md</u>				24a. REC'D BY REGISTRAR <u>Leah L. Repk</u>		24b. REGISTRAR'S SIGNATURE <u>Leah L. Repk</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

DEC 23 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 4 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND. STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12954 CERTIFICATE OF DEATH

12946

Reg. Dist. No.

76

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Westminster</u>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Westminster</u>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION			d. STREET ADDRESS <u>RD #3</u>		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <u>FANNIE PIPER</u> First Middle Last			4. DATE OF DEATH <u>Dec. 14</u> Month Day Year <u>1957</u>		
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 20, 1873</u>	9. AGE (In years last birthday) <u>84</u> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	11. BIRTHPLACE (State or foreign country) <u>Mt. Savage, Md.</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>Samuel Luther Piper</u>			14. MOTHER'S MAIDEN NAME <u>Mrs. Samuel L. Piper</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		
			17. INFORMANT <u>J. J. Miller</u> Address <u>RD #3</u>		

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Cerebral Hemorrhage</u> <u>331X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized Atherosclerosis</u> DUE TO (c) <u>20 years</u>			INTERVAL BETWEEN ONSET AND DEATH <u>6 days</u>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>12/9</u> 19 <u>57</u> , to <u>12/14</u> 19 <u>57</u> , that I last saw the deceased alive on <u>12/14</u> 19 <u>57</u> , and that death occurred at <u>6 A.</u> M. from the causes and on the date stated above.					
ACTUAL SIGNATURE <u>Shirley Bare</u>			ADDRESS (Street, city or town, state) <u>Westminster, Maryland</u>		
PHYSICIAN'S NAME (Type) <u>S. LUTHER BARE</u>			DATE SIGNED <u>12/14/57</u>		
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)
<u>Burial</u>		<u>Dec 16, 57</u>	<u>Mt. Savage, Md. Co.</u>		<u>Mt. Savage, Md. Co.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. J. Miller</u>			24a. REC'D BY REGISTRAR <u>J. J. Miller</u>		
ADDRESS <u>Westminster, Md.</u>			24b. REGISTRAR'S SIGNATURE <u>J. J. Miller</u>		
DATE <u>Dec 15, 1957</u>					

ARLIND STATE DEPARTMENT OF HEALTH—BALTIMORE 18

DEC 17 1957

RECEIVED

BUREAU A. M.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12955 CERTIFICATE OF DEATH

12947

Reg. Dist. No. 174

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>City</u> ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sykesville</u>			c. LENGTH OF STAY IN 1b <u>10 m 26 d</u>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore 14,</u> <u>3701.4</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Springfield State Hospital</u>				d. STREET ADDRESS <u>3612 Echodale Avenue</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Winifred</u> Middle <u>Josephine</u> Last <u>Duffy</u>				4. DATE OF DEATH Month <u>12</u> Day <u>29</u> Year <u>19 57</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>3-3-1900</u>	
9. AGE (In years last birthday) <u>57</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>James Flaherty</u>				14. MOTHER'S MAIDEN NAME <u>Mary</u> <u>Havin</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>unkn</u>		17. INFORMANT <u>Spr. Hospit. Records</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic cardiovascular disease</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>447.2</u> <u>Atrophic lateral sclerosis, Decubitus ulcer</u>							INTERVAL BETWEEN ONSET AND DEATH <u>days</u> <u>years</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>5-2-</u> , 19 <u>57</u> , to <u>12-29-</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>12-29-</u> , 19 <u>57</u> , and that death occurred at <u>10:30A</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Edmund Lusthaus</u> M.D. <u>Springfield State Hospital</u>				DATE SIGNED <u>12-29-57</u>			
PHYSICIAN'S NAME (Type) <u>Edmund Lusthaus M.D.</u>				ADDRESS (Street, city or town, state) <u>Sykesville, Maryland.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>1-2-58</u>		<u>1-2-58</u>		<u>New Cathedral</u>		<u>Baltimore Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Leonard J. Luck</u>				ADDRESS <u>5305 Harford</u>		24a. REC'D BY REGISTRAR DATE <u>12-29-57</u>	
				24b. REGISTRAR'S SIGNATURE <u>C. Harry</u>			

CERTIFICATE OF DEATH

See 201.10

<p>1. NAME OF DECEASED [REDACTED]</p>		<p>2. SEX [REDACTED]</p>		<p>3. AGE [REDACTED]</p>	
<p>4. DATE OF DEATH [REDACTED]</p>		<p>5. TIME OF DEATH [REDACTED]</p>		<p>6. PLACE OF DEATH [REDACTED]</p>	
<p>7. CAUSE OF DEATH [REDACTED]</p>		<p>8. MANNER OF DEATH [REDACTED]</p>		<p>9. PLACE OF BIRTH [REDACTED]</p>	
<p>10. OCCUPATION [REDACTED]</p>		<p>11. MARITAL STATUS [REDACTED]</p>		<p>12. EDUCATION [REDACTED]</p>	
<p>13. PREVIOUS ILLNESS [REDACTED]</p>		<p>14. MEDICAL HISTORY [REDACTED]</p>		<p>15. SIGNATURE OF DECEASED [REDACTED]</p>	
<p>16. SIGNATURE OF WITNESS [REDACTED]</p>		<p>17. SIGNATURE OF DECEASED [REDACTED]</p>		<p>18. SIGNATURE OF WITNESS [REDACTED]</p>	
<p>19. SIGNATURE OF DECEASED [REDACTED]</p>		<p>20. SIGNATURE OF WITNESS [REDACTED]</p>		<p>21. SIGNATURE OF DECEASED [REDACTED]</p>	
<p>22. SIGNATURE OF WITNESS [REDACTED]</p>		<p>23. SIGNATURE OF DECEASED [REDACTED]</p>		<p>24. SIGNATURE OF WITNESS [REDACTED]</p>	
<p>25. SIGNATURE OF DECEASED [REDACTED]</p>		<p>26. SIGNATURE OF WITNESS [REDACTED]</p>		<p>27. SIGNATURE OF DECEASED [REDACTED]</p>	
<p>28. SIGNATURE OF WITNESS [REDACTED]</p>		<p>29. SIGNATURE OF DECEASED [REDACTED]</p>		<p>30. SIGNATURE OF WITNESS [REDACTED]</p>	
<p>31. SIGNATURE OF DECEASED [REDACTED]</p>		<p>32. SIGNATURE OF WITNESS [REDACTED]</p>		<p>33. SIGNATURE OF DECEASED [REDACTED]</p>	
<p>34. SIGNATURE OF WITNESS [REDACTED]</p>		<p>35. SIGNATURE OF DECEASED [REDACTED]</p>		<p>36. SIGNATURE OF WITNESS [REDACTED]</p>	
<p>37. SIGNATURE OF DECEASED [REDACTED]</p>		<p>38. SIGNATURE OF WITNESS [REDACTED]</p>		<p>39. SIGNATURE OF DECEASED [REDACTED]</p>	
<p>40. SIGNATURE OF WITNESS [REDACTED]</p>		<p>41. SIGNATURE OF DECEASED [REDACTED]</p>		<p>42. SIGNATURE OF WITNESS [REDACTED]</p>	
<p>43. SIGNATURE OF DECEASED [REDACTED]</p>		<p>44. SIGNATURE OF WITNESS [REDACTED]</p>		<p>45. SIGNATURE OF DECEASED [REDACTED]</p>	
<p>46. SIGNATURE OF WITNESS [REDACTED]</p>		<p>47. SIGNATURE OF DECEASED [REDACTED]</p>		<p>48. SIGNATURE OF WITNESS [REDACTED]</p>	
<p>49. SIGNATURE OF DECEASED [REDACTED]</p>		<p>50. SIGNATURE OF WITNESS [REDACTED]</p>		<p>51. SIGNATURE OF DECEASED [REDACTED]</p>	
<p>52. SIGNATURE OF WITNESS [REDACTED]</p>		<p>53. SIGNATURE OF DECEASED [REDACTED]</p>		<p>54. SIGNATURE OF WITNESS [REDACTED]</p>	
<p>55. SIGNATURE OF DECEASED [REDACTED]</p>		<p>56. SIGNATURE OF WITNESS [REDACTED]</p>		<p>57. SIGNATURE OF DECEASED [REDACTED]</p>	
<p>58. SIGNATURE OF WITNESS [REDACTED]</p>		<p>59. SIGNATURE OF DECEASED [REDACTED]</p>		<p>60. SIGNATURE OF WITNESS [REDACTED]</p>	
<p>61. SIGNATURE OF DECEASED [REDACTED]</p>		<p>62. SIGNATURE OF WITNESS [REDACTED]</p>		<p>63. SIGNATURE OF DECEASED [REDACTED]</p>	
<p>64. SIGNATURE OF WITNESS [REDACTED]</p>		<p>65. SIGNATURE OF DECEASED [REDACTED]</p>		<p>66. SIGNATURE OF WITNESS [REDACTED]</p>	
<p>67. SIGNATURE OF DECEASED [REDACTED]</p>		<p>68. SIGNATURE OF WITNESS [REDACTED]</p>		<p>69. SIGNATURE OF DECEASED [REDACTED]</p>	
<p>70. SIGNATURE OF WITNESS [REDACTED]</p>		<p>71. SIGNATURE OF DECEASED [REDACTED]</p>		<p>72. SIGNATURE OF WITNESS [REDACTED]</p>	
<p>73. SIGNATURE OF DECEASED [REDACTED]</p>		<p>74. SIGNATURE OF WITNESS [REDACTED]</p>		<p>75. SIGNATURE OF DECEASED [REDACTED]</p>	
<p>76. SIGNATURE OF WITNESS [REDACTED]</p>		<p>77. SIGNATURE OF DECEASED [REDACTED]</p>		<p>78. SIGNATURE OF WITNESS [REDACTED]</p>	
<p>79. SIGNATURE OF DECEASED [REDACTED]</p>		<p>80. SIGNATURE OF WITNESS [REDACTED]</p>		<p>81. SIGNATURE OF DECEASED [REDACTED]</p>	
<p>82. SIGNATURE OF WITNESS [REDACTED]</p>		<p>83. SIGNATURE OF DECEASED [REDACTED]</p>		<p>84. SIGNATURE OF WITNESS [REDACTED]</p>	
<p>85. SIGNATURE OF DECEASED [REDACTED]</p>		<p>86. SIGNATURE OF WITNESS [REDACTED]</p>		<p>87. SIGNATURE OF DECEASED [REDACTED]</p>	
<p>88. SIGNATURE OF WITNESS [REDACTED]</p>		<p>89. SIGNATURE OF DECEASED [REDACTED]</p>		<p>90. SIGNATURE OF WITNESS [REDACTED]</p>	
<p>91. SIGNATURE OF DECEASED [REDACTED]</p>		<p>92. SIGNATURE OF WITNESS [REDACTED]</p>		<p>93. SIGNATURE OF DECEASED [REDACTED]</p>	
<p>94. SIGNATURE OF WITNESS [REDACTED]</p>		<p>95. SIGNATURE OF DECEASED [REDACTED]</p>		<p>96. SIGNATURE OF WITNESS [REDACTED]</p>	
<p>97. SIGNATURE OF DECEASED [REDACTED]</p>		<p>98. SIGNATURE OF WITNESS [REDACTED]</p>		<p>99. SIGNATURE OF DECEASED [REDACTED]</p>	
<p>100. SIGNATURE OF WITNESS [REDACTED]</p>		<p>101. SIGNATURE OF DECEASED [REDACTED]</p>		<p>102. SIGNATURE OF WITNESS [REDACTED]</p>	

BUREAU V. S.

JAN 6 1958

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12948

12956 CERTIFICATE OF DEATH

Reg. Dist. No.

74

1. PLACE OF DEATH o. COUNTY <u>Carroll</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sykesville</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X2 Sykesville</u>			
c. LENGTH OF STAY IN 1b <u>1 m 16 d</u>				d. STREET ADDRESS <u>Rt # 1.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Springfield State Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>Lella</u> Last <u>Dwyer</u>		4. DATE OF DEATH Month <u>12</u> Day <u>28</u> Year <u>19 57</u>					
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10 - 1 - 89</u>	9. AGE (In years last birthday) <u>68</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housekeeper</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Holland</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth Duvall</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>unkn</u>		17. INFORMANT <u>S.S. Hospital Records</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hemorrhage from lenticulostr. artery</u> <u>331X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Gener. Arteriosclerosis</u> DUE TO (c) <u> </u>						INTERVAL BETWEEN ONSET AND DEATH <u>hours</u> <u>years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>C.B.S. due to Arterioscler. Diabetes Mellitus</u> <u>260X</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. 11 p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Nov. 12, 19 57</u> , to <u>Dec. 28 19 57</u> , that I last saw the deceased alive on <u>Dec. 28, 19 57</u> , and that death occurred at <u>9 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Edmund Lusthaus</u>		ADDRESS (Street, city or town, state) <u>M.D. Springfield State Hospital</u>				DATE SIGNED <u>12-29-57</u>	
PHYSICIAN'S NAME (Type) <u>Edmund Lusthaus</u>		<u>Sykesville, Maryland.</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>12-31-1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mt. View</u>		22d. LOCATION (City, town, or county) (State) <u>Howard Co., Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>C. M. Waltz,</u>				ADDRESS <u>Winfield, Md.</u>		24a. REC'D BY REGISTRAR <u>JAN 2 1958</u>	
				24b. REGISTRAR'S SIGNATURE <u>Harry Herz</u>			

CERTIFICATE OF DEATH

MASSACHUSETTS STATE DEPARTMENT OF HEALTH - BOSTON

FILE NO.

REGISTERED

DATE

PLACE OF DEATH

RESIDENCE

AGE

SEX

CAUSE OF DEATH

MANNER OF DEATH

DATE OF DEATH

TIME OF DEATH

PLACE OF BIRTH

DATE OF BIRTH

NAME OF DECEASED

NAME OF FATHER

NAME OF MOTHER

NAME OF SPOUSE

NAME OF NEXT OF KIN

NAME OF PHYSICIAN

NAME OF BURIAL PLACE

NAME OF MINISTER

NAME OF CLERGYMAN

NAME OF CHURCH

NAME OF CEMETERY

NAME OF INTERVIEWER

NAME OF REGISTRAR

NAME OF CLERK

NAME OF ASSISTANT

NAME OF DEPUTY

NAME OF SHERIFF

NAME OF JAILER

NAME OF WARDEN

NAME OF CHIEF

NAME OF DEPUTY CHIEF

NAME OF CLERK

NAME OF ASSISTANT CLERK

NAME OF DEPUTY ASSISTANT CLERK

BUREAU V. S.

JAN 2 1909

RECEIVED

12957 CERTIFICATE OF DEATH

Reg. Dist. No.

74

1. PLACE OF DEATH o. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Frederick			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville				c. LENGTH OF STAY IN 1b 2 yrs 8 mons.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rocky Ridge 10X12			
d. STREET ADDRESS none				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Elsie Middle Anna Last Eigenbrode				4. DATE OF DEATH Month December Day 2 Year 19 57			
5. SEX Female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-28-82	9. AGE (In years last birthday) 74 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY none		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Henry Dotterer				14. MOTHER'S MAIDEN NAME Mary Catherine Roop			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none		17. INFORMANT Husband		Address Rocky Ridge, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arterio- Sclerosis DUE TO (c) 10 years						INTERVAL BETWEEN ONSET AND DEATH 24 hours	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that I attended the deceased from May 26 , 19 55 , to December 2 , 19 57 , that I last saw the deceased alive on December 2 , 19 57 , and that death occurred at 3:45 A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE M. N. Mastin		M.D. Sykesville, Md.		ADDRESS (Street, city or town, state) Sykesville, Md.			
PHYSICIAN'S NAME (Type) Dr. M. N. Mastin M.D.		LOCATION (City, town, or county) (State) Sykesville, Maryland					
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 12/5/57	22c. NAME OF CEMETERY OR CREMATORY CHURCH OF BROTHERN	22d. LOCATION (City, town, or county) (State) ROCKY RIDGE MARYLAND				
23. FUNERAL DIRECTOR'S SIGNATURE Raymond E. Creager		ADDRESS Thurmont, Md.		24a. REC'D BY REGISTRAR DEC 5 1957	24b. REGISTRAR'S SIGNATURE Cherry Tree		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 could be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH		CITY		STATE		COUNTRY	
JAMES H. HARRIS		58		M		W		1891		BALTIMORE		MD		MD		USA	
OCCUPATION		EDUCATION		MARRIAGE		RELIGION		DATE OF DEATH		PLACE OF DEATH		CITY		STATE		COUNTRY	
Carpenter		High School		Married		Catholic		1957		BALTIMORE		MD		MD		USA	
CAUSE OF DEATH		MANNER OF DEATH		DATE OF EXAMINATION		PLACE OF EXAMINATION		CITY		STATE		COUNTRY		DATE OF REPORT		PLACE OF REPORT	
Heart Disease		Natural		1957		BALTIMORE		MD		MD		USA		1957		BALTIMORE	

BUREAU V. S.

DEC 5 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12958

CERTIFICATE OF DEATH

12950

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Taneytown</u>		c. LENGTH OF STAY in 1b <u>Life</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Taneytown</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION			d. STREET ADDRESS <u>1</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>George Marlin Fair</u>			4. DATE OF DEATH Month Day Year <u>December 26 19 57</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 22, 1905</u>		9. AGE (In years last birthday) <u>52</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Truck Driver</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Freight Hauling</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
13. FATHER'S NAME <u>Birnie W. Fair</u>			14. MOTHER'S MAIDEN NAME <u>Margaret R. Vaughn</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>215-20-8142</u>		17. INFORMANT Address <u>Mrs. Marlin Fair, Taneytown, Maryland</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>154X</u> <u>Dementia</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Urinary Obstruction</u> DUE TO (c) <u>Carcinoma of Rectum</u>					INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u> <u>1 mo</u> <u>July 1956</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>July</u> , 19 <u>56</u> , to <u>12-26</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>12-13</u> , 19 <u>57</u> , and that death occurred at <u>7 A.</u> M., from the causes and on the date stated above.					
ACTUAL SIGNATURE <u>E. Ambler Thompson</u> M.D.			ADDRESS (Street, city or town, state) <u>Taneytown, Md.</u>		DATE SIGNED <u>Dec 22, 1957</u>
PHYSICIAN'S NAME (Type) <u>E. Ambler Thompson, M.D.</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12/29/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Lutheran Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Taneytown, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>C.O. Fuss & Son</u>			24a. REC'D BY REGISTRAR ADDRESS <u>Taneytown, Md.</u>		24b. REGISTRAR'S SIGNATURE <u>W. Beach</u>

CERTIFICATE OF DEATH

1. NAME OF DECEASED JAMES H. HARRIS		2. SEX Male		3. AGE 65	
4. RACE White		5. BIRTH DATE 1890		6. BIRTH PLACE Maryland	
7. DEATH DATE 1957		8. DEATH TIME 10:00 AM		9. DEATH PLACE Home	
10. DEATH CAUSE Heart Disease		11. DEATH PLACE Home		12. DEATH TIME 10:00 AM	
13. DEATH PLACE Home		14. DEATH TIME 10:00 AM		15. DEATH PLACE Home	
16. DEATH TIME 10:00 AM		17. DEATH PLACE Home		18. DEATH TIME 10:00 AM	
19. DEATH PLACE Home		20. DEATH TIME 10:00 AM		21. DEATH PLACE Home	
22. DEATH TIME 10:00 AM		23. DEATH PLACE Home		24. DEATH TIME 10:00 AM	
25. DEATH PLACE Home		26. DEATH TIME 10:00 AM		27. DEATH PLACE Home	
28. DEATH TIME 10:00 AM		29. DEATH PLACE Home		30. DEATH TIME 10:00 AM	
31. DEATH PLACE Home		32. DEATH TIME 10:00 AM		33. DEATH PLACE Home	
34. DEATH TIME 10:00 AM		35. DEATH PLACE Home		36. DEATH TIME 10:00 AM	
37. DEATH PLACE Home		38. DEATH TIME 10:00 AM		39. DEATH PLACE Home	
40. DEATH TIME 10:00 AM		41. DEATH PLACE Home		42. DEATH TIME 10:00 AM	
43. DEATH PLACE Home		44. DEATH TIME 10:00 AM		45. DEATH PLACE Home	
46. DEATH TIME 10:00 AM		47. DEATH PLACE Home		48. DEATH TIME 10:00 AM	
49. DEATH PLACE Home		50. DEATH TIME 10:00 AM		51. DEATH PLACE Home	
52. DEATH TIME 10:00 AM		53. DEATH PLACE Home		54. DEATH TIME 10:00 AM	
55. DEATH PLACE Home		56. DEATH TIME 10:00 AM		57. DEATH PLACE Home	
58. DEATH TIME 10:00 AM		59. DEATH PLACE Home		60. DEATH TIME 10:00 AM	
61. DEATH PLACE Home		62. DEATH TIME 10:00 AM		63. DEATH PLACE Home	
64. DEATH TIME 10:00 AM		65. DEATH PLACE Home		66. DEATH TIME 10:00 AM	
67. DEATH PLACE Home		68. DEATH TIME 10:00 AM		69. DEATH PLACE Home	
70. DEATH TIME 10:00 AM		71. DEATH PLACE Home		72. DEATH TIME 10:00 AM	
73. DEATH PLACE Home		74. DEATH TIME 10:00 AM		75. DEATH PLACE Home	
76. DEATH TIME 10:00 AM		77. DEATH PLACE Home		78. DEATH TIME 10:00 AM	
79. DEATH PLACE Home		80. DEATH TIME 10:00 AM		81. DEATH PLACE Home	
82. DEATH TIME 10:00 AM		83. DEATH PLACE Home		84. DEATH TIME 10:00 AM	
85. DEATH PLACE Home		86. DEATH TIME 10:00 AM		87. DEATH PLACE Home	
88. DEATH TIME 10:00 AM		89. DEATH PLACE Home		90. DEATH TIME 10:00 AM	
91. DEATH PLACE Home		92. DEATH TIME 10:00 AM		93. DEATH PLACE Home	
94. DEATH TIME 10:00 AM		95. DEATH PLACE Home		96. DEATH TIME 10:00 AM	
97. DEATH PLACE Home		98. DEATH TIME 10:00 AM		99. DEATH PLACE Home	
100. DEATH TIME 10:00 AM		101. DEATH PLACE Home		102. DEATH TIME 10:00 AM	

BUREAU V. 1

DEC 30 1957

RECEIVED

12959 CERTIFICATE OF DEATH

12951

Reg. Dist. No. 74

1. PLACE OF DEATH o. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Henryton				c. LENGTH OF STAY IN 1b 7 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Henryton State Hospital				d. STREET ADDRESS 404 Green Street			
3. NAME OF DECEASED (Type or print) First Martha Middle Last Farmer				4. DATE OF DEATH Month 12 Day 4 Year 1957			
5. SEX Female		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 6-28-1900	
9. AGE (In years lost birthday) 57 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unknown		10b. KIND OF BUSINESS OR INDUSTRY Middlesex Co., Virginia	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Charlie Jackson		14. MOTHER'S MAIDEN NAME Elizabeth Richardson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Address Martha Farmer - 404 Green Street			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Far advanced bilateral cavitory pulmonary Tbc. DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				21. I certify that I attended the deceased from November 27, 1957 , to December 4, 1957 , that I last saw the deceased alive on December 4, 1957 , and that death occurred at 5 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Edgar M. Maculans M.D.				ADDRESS (Street, city or town, state) Henryton, Maryland		DATE SIGNED 12-4-57	
PHYSICIAN'S NAME (Type) Dr. Edgar Maculans, Supt.				Henryton State Hospital			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF 12/5/57		22c. NAME OF CEMETERY OR CREMATORY Not above		22d. LOCATION (City, town, or county) (State) Baltimore, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE A. Halstead				ADDRESS 9/8 S. ...		24b. REGISTRAR'S SIGNATURE Robert R. ...	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

DEC 9 1957

BUREAU V. 3

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, MD	
1957 CERTIFICATE OF DEATH	
1. NAME OF DECEASED	
2. SEX	
3. AGE	
4. DATE OF BIRTH	
5. PLACE OF BIRTH	
6. OCCUPATION	
7. CAUSE OF DEATH	
8. PLACE OF DEATH	
9. DATE OF DEATH	
10. SIGNATURE OF DECEASED	
11. SIGNATURE OF WITNESS	
12. SIGNATURE OF PHYSICIAN	
13. SIGNATURE OF CORONER	
14. SIGNATURE OF JURY	
15. SIGNATURE OF JUDGE	
16. SIGNATURE OF CLERK	
17. SIGNATURE OF REGISTRAR	
18. SIGNATURE OF NOTARY	
19. SIGNATURE OF SHERIFF	
20. SIGNATURE OF DEPUTY SHERIFF	
21. SIGNATURE OF CONSTABLE	
22. SIGNATURE OF DEPUTY CONSTABLE	
23. SIGNATURE OF JURY	
24. SIGNATURE OF JUDGE	
25. SIGNATURE OF CLERK	
26. SIGNATURE OF REGISTRAR	
27. SIGNATURE OF NOTARY	
28. SIGNATURE OF SHERIFF	
29. SIGNATURE OF DEPUTY SHERIFF	
30. SIGNATURE OF CONSTABLE	
31. SIGNATURE OF DEPUTY CONSTABLE	
32. SIGNATURE OF JURY	
33. SIGNATURE OF JUDGE	
34. SIGNATURE OF CLERK	
35. SIGNATURE OF REGISTRAR	
36. SIGNATURE OF NOTARY	
37. SIGNATURE OF SHERIFF	
38. SIGNATURE OF DEPUTY SHERIFF	
39. SIGNATURE OF CONSTABLE	
40. SIGNATURE OF DEPUTY CONSTABLE	
41. SIGNATURE OF JURY	
42. SIGNATURE OF JUDGE	
43. SIGNATURE OF CLERK	
44. SIGNATURE OF REGISTRAR	
45. SIGNATURE OF NOTARY	
46. SIGNATURE OF SHERIFF	
47. SIGNATURE OF DEPUTY SHERIFF	
48. SIGNATURE OF CONSTABLE	
49. SIGNATURE OF DEPUTY CONSTABLE	
50. SIGNATURE OF JURY	
51. SIGNATURE OF JUDGE	
52. SIGNATURE OF CLERK	
53. SIGNATURE OF REGISTRAR	
54. SIGNATURE OF NOTARY	
55. SIGNATURE OF SHERIFF	
56. SIGNATURE OF DEPUTY SHERIFF	
57. SIGNATURE OF CONSTABLE	
58. SIGNATURE OF DEPUTY CONSTABLE	
59. SIGNATURE OF JURY	
60. SIGNATURE OF JUDGE	
61. SIGNATURE OF CLERK	
62. SIGNATURE OF REGISTRAR	
63. SIGNATURE OF NOTARY	
64. SIGNATURE OF SHERIFF	
65. SIGNATURE OF DEPUTY SHERIFF	
66. SIGNATURE OF CONSTABLE	
67. SIGNATURE OF DEPUTY CONSTABLE	
68. SIGNATURE OF JURY	
69. SIGNATURE OF JUDGE	
70. SIGNATURE OF CLERK	
71. SIGNATURE OF REGISTRAR	
72. SIGNATURE OF NOTARY	
73. SIGNATURE OF SHERIFF	
74. SIGNATURE OF DEPUTY SHERIFF	
75. SIGNATURE OF CONSTABLE	
76. SIGNATURE OF DEPUTY CONSTABLE	
77. SIGNATURE OF JURY	
78. SIGNATURE OF JUDGE	
79. SIGNATURE OF CLERK	
80. SIGNATURE OF REGISTRAR	
81. SIGNATURE OF NOTARY	
82. SIGNATURE OF SHERIFF	
83. SIGNATURE OF DEPUTY SHERIFF	
84. SIGNATURE OF CONSTABLE	
85. SIGNATURE OF DEPUTY CONSTABLE	
86. SIGNATURE OF JURY	
87. SIGNATURE OF JUDGE	
88. SIGNATURE OF CLERK	
89. SIGNATURE OF REGISTRAR	
90. SIGNATURE OF NOTARY	
91. SIGNATURE OF SHERIFF	
92. SIGNATURE OF DEPUTY SHERIFF	
93. SIGNATURE OF CONSTABLE	
94. SIGNATURE OF DEPUTY CONSTABLE	
95. SIGNATURE OF JURY	
96. SIGNATURE OF JUDGE	
97. SIGNATURE OF CLERK	
98. SIGNATURE OF REGISTRAR	
99. SIGNATURE OF NOTARY	
100. SIGNATURE OF SHERIFF	

12960 CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN 1b 3 years	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore City		3601-4	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital		d. STREET ADDRESS 1603 East 30th St.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Margaret Middle Marie Last Fitzgerald		4. DATE OF DEATH Month December Day 4 Year 1957	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-7-1871
9. AGE (In years last birthday) 86 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Drug Packer		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A	
13. FATHER'S NAME John J. Fitzgerald		14. MOTHER'S MAIDEN NAME Nora Kerwick	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 214-01-9170	
17. INFORMANT Mrs. Evelyn R. Mudd		322 Address Longfellow St. N. W. Washington D.C.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) Hypertensive Cardio-vascular disease DUE TO (c) Generalized Arteriosclerosis			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic brain syndrome associated with senile brain disease, with psychosis			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 11/24/54 , 19____, to 12/4/57 , 19____, that I last saw the deceased alive on 12/4 , 19____, and that death occurred at _____ M, from the causes and on the date stated above.			
ADDRESS (Street, city or town, state) Springfield State Hosp. Sykesville, Md.		DATE SIGNED 12/5/57	
ACTUAL SIGNATURE Irene L. Hitchman		PHYSICIAN'S NAME (Type) Irene L. Hitchman, M. D. Springfield State Hosp., Sykesville	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 12/9/57	22c. NAME OF CEMETERY OR CREMATORY NEW CATHEDRAL	22d. LOCATION (City, town, or county) (State) BALTIMORE MD
23. FUNERAL DIRECTOR'S SIGNATURE Charles F. Grooms		ADDRESS 118 W. Mt. Royal	
24a. REC'D BY REGISTRAR DEC 9 1957		24b. REGISTRAR'S SIGNATURE Harry Hays	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Page One of Two

<p>1. Name of Deceased: <u>JOHN J. SMITH</u></p>		<p>2. Sex: <u>Male</u></p>	
<p>3. Date of Birth: <u>1915-03-15</u></p>		<p>4. Place of Birth: <u>NEW YORK, N.Y.</u></p>	
<p>5. Date of Death: <u>1957-12-08</u></p>		<p>6. Place of Death: <u>HOME</u></p>	
<p>7. Cause of Death: <u>HEART DISEASE</u></p>		<p>8. Manner of Death: <u>NATURAL</u></p>	
<p>9. Physician: <u>DR. J. H. BROWN</u></p>		<p>10. Hospital: <u>None</u></p>	
<p>11. Burial Place: <u>St. Mary's Cemetery</u></p>		<p>12. Burial Date: <u>1957-12-10</u></p>	
<p>13. Signature of Physician: <u>[Signature]</u></p>		<p>14. Signature of Registrar: <u>[Signature]</u></p>	
<p>15. Date of Registration: <u>1957-12-10</u></p>		<p>16. Office: <u>State Department of Health</u></p>	

BUREAU V. S.

DEC 9 1957

RECEIVED

12961 CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH o. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville				c. LENGTH OF STAY IN 1b since 11/1/17			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore City 3401-4			
				d. STREET ADDRESS Unknown			
3. NAME OF DECEASED (Type or print) First Frank Middle Lost Foley				4. DATE OF DEATH Month December Day 16 Year 19 57			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1883	
9. AGE (In years lost birthday) 74 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Tailor				10b. KIND OF BUSINESS OR INDUSTRY Tailor		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Mike Foley				14. MOTHER'S MAIDEN NAME Mary Dean			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. Ynk		17. INFORMANT Records of Springfield State Hospital			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Psychosis with mental deficiency							INTERVAL BETWEEN ONSET AND DEATH minutes
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) ---
20c. TIME OF INJURY Hour o. m. p. m. --- 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) *		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from September 1 19 47 , to December 16 19 57 , that I last saw the deceased alive on December 16 19 57 , and that death occurred at 11:00 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Springfield State Hospital, Sykesville, Maryland DATE SIGNED 12/16/57							
ACTUAL SIGNATURE Walther H. Sonnenfeldt M.D.							
PHYSICIAN'S NAME (Type) Walther H. Sonnenfeldt, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF 12-18-57		22c. NAME OF CEMETERY OR CREMATORY New Calhoun		22d. LOCATION (City, town, or county) (State) Baltimore, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Ruth H. Haight				ADDRESS Sykesville, Md.		24a. REC'D BY REGISTRAR DATE 12-18-57	
				24b. REGISTRAR'S SIGNATURE C. Harry Wuer			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

DEC 23 1957

BUREAU V. 81

CERTIFICATE OF DEATH

1957

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

1. NAME OF DECEASED [Faint text]		2. SEX [Faint text]	
3. AGE [Faint text]		4. DATE OF BIRTH [Faint text]	
5. PLACE OF BIRTH [Faint text]		6. OCCUPATION [Faint text]	
7. MARITAL STATUS [Faint text]		8. CAUSE OF DEATH [Faint text]	
9. PLACE OF DEATH [Faint text]		10. TIME OF DEATH [Faint text]	
11. SIGNATURE OF PHYSICIAN [Faint text]		12. SIGNATURE OF REGISTRAR [Faint text]	
13. SIGNATURE OF WITNESSES [Faint text]		14. SIGNATURE OF DECEASED [Faint text]	
15. SIGNATURE OF FUNERAL HOME [Faint text]		16. SIGNATURE OF BURIAL PLACE [Faint text]	
17. SIGNATURE OF CEMETERY [Faint text]		18. SIGNATURE OF INTERMENT [Faint text]	
19. SIGNATURE OF BURIAL PLACE [Faint text]		20. SIGNATURE OF INTERMENT [Faint text]	
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89. SIGNATURE OF BURIAL PLACE [Faint text]		90. SIGNATURE OF INTERMENT [Faint text]	
91. SIGNATURE OF BURIAL PLACE [Faint text]		92. SIGNATURE OF INTERMENT [Faint text]	
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95. SIGNATURE OF BURIAL PLACE [Faint text]		96. SIGNATURE OF INTERMENT [Faint text]	
97. SIGNATURE OF BURIAL PLACE [Faint text]		98. SIGNATURE OF INTERMENT [Faint text]	
99. SIGNATURE OF BURIAL PLACE [Faint text]		100. SIGNATURE OF INTERMENT [Faint text]	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 7 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 7 and 2 should be filed with the registrar or prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
12962 CERTIFICATE OF DEATH

12954
74

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Carroll	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN 1b 1 yr.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Pullen Nursing Home		e. STREET ADDRESS 1	
3. NAME OF DECEASED (Type or print) First CLARA Middle H. Last FRANKLIN		4. DATE OF DEATH Month Dec. Day 13 Year 1957	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 7, 1877
9. AGE (In years last birthday) 80 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY home	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Lewis Koontz		14. MOTHER'S MAIDEN NAME Mary Spurrier	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. -----	
17. INFORMANT Mrs. Edward Will, R.D. Westminster, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac arrest, arteriosclerotic heart Dis. 422.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cerebral thrombosis, left hemiplegia. DUE TO (c) Parkinson's Disease		INTERVAL BETWEEN ONSET AND DEATH 1956 to Dec 1957	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1956 , 19____, to Dec , 19 57 , that I last saw the deceased alive on 13 Dec , 19 57 , and that death occurred at 6:20 P.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE Howard E. Hall		ADDRESS (Street, city or town, state) Ashworth, Md	
PHYSICIAN'S NAME (Type) HOWARD E. HALL		DATE SIGNED 13 Dec 57	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 12-16-1957	
22c. NAME OF CEMETERY OR CREMATOR Sams Creek Brethren		22d. LOCATION (City, town, or county) (State) Carroll Co., Md	
23. FUNERAL DIRECTOR'S SIGNATURE C. M. Waltz,		24. REC'D BY REGISTRAR DEC 17 1957	
ADDRESS Winfield, Md.		24b. REGISTRAR'S SIGNATURE C. Harry Perry	

BUREAU V. S.

DEC 17 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

: 12963 CERTIFICATE OF DEATH

Reg. Dist. No. 76

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Carroll	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural, Westminster		c. LENGTH OF STAY IN 1b Life	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Uniontown District Westminster, Md. R. D. 7		d. STREET ADDRESS Uniontown District Westminster, Md. R. D. 7	
3. NAME OF DECEASED (Type or print) First Alice Middle Florence Last Garber		4. DATE OF DEATH Month 12 Day 17 Year 57	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/22/1917
9. AGE (In years last birthday) 40		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Supervisor		10b. KIND OF BUSINESS OR INDUSTRY Rubber Company	
11. BIRTHPLACE (State or foreign country) Carroll Co., Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William E. Flickinger		14. MOTHER'S MAIDEN NAME Bessie G. Miller	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 213-05-1632	
17. INFORMANT Clarence L. Garber		Address Clarence L. Garber, Westminster, Md. R.D.7	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinomatosis 199.9 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 3 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 3/1 , 19 54 , to 12/17 , 19 57 , that I last saw the deceased alive on 12/15 , 19 57 , and that death occurred at 12 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE M. E. Robertson		ADDRESS (Street, city or town, state) DATE SIGNED 12/17/57	
PHYSICIAN'S NAME (Type) M. E. Robertson		New Windsor, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/20/57	
22c. NAME OF CEMETERY OR CREMATORY Kriders Lutheran Cem.		22d. LOCATION (City, town, or county) (State) Nr. Westminster, Carroll Co. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Richard A. Little		ADDRESS Littlestown, Pa.	
24a. REC'D BY REGISTRAR DEC 19 1957		24b. REGISTRAR'S SIGNATURE Harnet Miller	

DEC 19 1957

Mr. L. A. Harris

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville				c. LENGTH OF STAY IN 1b 0102.2			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital				d. STREET ADDRESS 212 Fulton St.			
3. NAME OF DECEASED (Type or print) First Edna Middle David Last GATEHOUSE				4. DATE OF DEATH Month 12 - Day 28 Year 19 57			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH August 7, 1886	
9. AGE (In years last birthday) 71 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Chiropractor				10b. KIND OF BUSINESS OR INDUSTRY UNK		11. BIRTHPLACE (State or foreign country) South Carolina	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME John H. David				14. MOTHER'S MAIDEN NAME Arletta Manning			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Ysch		17. INFORMANT Springfield Hospital Records			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cancer of the bladder 181X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) C.B.S. associated with senile brain disease with psychotic reaction.							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from September 25, 1957 , to Dec. 28, 1957 , that I last saw the deceased alive on Dec. 28, 1957 , and that death occurred at 7 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Springfield State Hospital DATE SIGNED 12-29-57 ACTUAL SIGNATURE Edmund Lusthaus M.D. PHYSICIAN'S NAME (Type) Edmund Lusthaus M.D. Sykesville, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
Burial		1-2-58		Willow		Willow, D.C.	
23. FUNERAL DIRECTOR'S SIGNATURE Richard A. Haight				ADDRESS Sykesville, Md.		24a. REC'D BY REGISTRAR DATE 12-29-57	
				24b. REGISTRAR'S SIGNATURE C. Henry			

BUREAU V. S.

DEC 31 1957

RECEIVED

Item 2, Film G223, 12/23/57

12965

CERTIFICATE OF DEATH

Reg. Dist. No.

74

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 1 yr, 2 mo, 20 dys Olney Chevy Chase 15X2.2			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital				d. STREET ADDRESS 7116 Edgevale Street Brook Grove Foundation			
3. NAME OF DECEASED (Type or print) First Mary Middle Louise Last Giddings				4. DATE OF DEATH Month December Day 11 Year 1957			
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 20, 1873		9. AGE (In years last birthday) 84 yrs.	IF UNDER 1 YEAR Months 84 Days 84 Hours 84 Min. 84	IF UNDER 24 HRS. Hours 84 Min. 84
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Practical nurse		10b. KIND OF BUSINESS OR INDUSTRY in private homes		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William Friend				14. MOTHER'S MAIDEN NAME Lelia Aiken			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. unk.		17. INFORMANT Springfield Hospital records			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion DUE TO Arteriosclerotic heart disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized arteriosclerosis (c) Chronic brain syndrome associated with circulatory disturbance, with cerebral arteriosclerosis, with psychotic reaction						INTERVAL BETWEEN ONSET AND DEATH minutes years years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic brain syndrome associated with circulatory disturbance, with cerebral arteriosclerosis, with psychotic reaction						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from September 21 1957 , to December 11 1957 , that I last saw the deceased alive on December 11, 1957 , and that death occurred at 6:45 A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Gertrud Sonnenfeldt				ADDRESS (Street, city or town, state) Springfield State Hospital DATE SIGNED 12/11/57			
PHYSICIAN'S NAME (Type) Gertrud Sonnenfeldt, M.D.				Sykesville, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/14/57		22c. NAME OF CEMETERY OR CREMATORY Leesburg, Va.		22d. LOCATION (City, town, or county) (State) Leesburg, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey-Bethesda, Md.				24a. REC'D BY REGISTRAR DATE			
				24b. REGISTRAR'S SIGNATURE C. Harry			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MD-201-1057

1. NAME OF DECEASED		2. SEX		3. AGE	
4. OCCUPATION		5. MARITAL STATUS		6. PLACE OF BIRTH	
7. DATE OF DEATH		8. TIME OF DEATH		9. CAUSE OF DEATH	
10. PLACE OF DEATH		11. SIGNATURE OF PHYSICIAN		12. SIGNATURE OF REGISTRAR	
13. DATE OF REGISTRATION		14. TIME OF REGISTRATION		15. PLACE OF REGISTRATION	
16. NAME OF REGISTRAR		17. SIGNATURE OF REGISTRAR		18. DATE OF REGISTRATION	
19. NAME OF PHYSICIAN		20. SIGNATURE OF PHYSICIAN		21. DATE OF REGISTRATION	
22. NAME OF REGISTRAR		23. SIGNATURE OF REGISTRAR		24. DATE OF REGISTRATION	
25. NAME OF PHYSICIAN		26. SIGNATURE OF PHYSICIAN		27. DATE OF REGISTRATION	
28. NAME OF REGISTRAR		29. SIGNATURE OF REGISTRAR		30. DATE OF REGISTRATION	
31. NAME OF PHYSICIAN		32. SIGNATURE OF PHYSICIAN		33. DATE OF REGISTRATION	
34. NAME OF REGISTRAR		35. SIGNATURE OF REGISTRAR		36. DATE OF REGISTRATION	
37. NAME OF PHYSICIAN		38. SIGNATURE OF PHYSICIAN		39. DATE OF REGISTRATION	
40. NAME OF REGISTRAR		41. SIGNATURE OF REGISTRAR		42. DATE OF REGISTRATION	
43. NAME OF PHYSICIAN		44. SIGNATURE OF PHYSICIAN		45. DATE OF REGISTRATION	
46. NAME OF REGISTRAR		47. SIGNATURE OF REGISTRAR		48. DATE OF REGISTRATION	
49. NAME OF PHYSICIAN		50. SIGNATURE OF PHYSICIAN		51. DATE OF REGISTRATION	
52. NAME OF REGISTRAR		53. SIGNATURE OF REGISTRAR		54. DATE OF REGISTRATION	
55. NAME OF PHYSICIAN		56. SIGNATURE OF PHYSICIAN		57. DATE OF REGISTRATION	
58. NAME OF REGISTRAR		59. SIGNATURE OF REGISTRAR		60. DATE OF REGISTRATION	
61. NAME OF PHYSICIAN		62. SIGNATURE OF PHYSICIAN		63. DATE OF REGISTRATION	
64. NAME OF REGISTRAR		65. SIGNATURE OF REGISTRAR		66. DATE OF REGISTRATION	
67. NAME OF PHYSICIAN		68. SIGNATURE OF PHYSICIAN		69. DATE OF REGISTRATION	
70. NAME OF REGISTRAR		71. SIGNATURE OF REGISTRAR		72. DATE OF REGISTRATION	
73. NAME OF PHYSICIAN		74. SIGNATURE OF PHYSICIAN		75. DATE OF REGISTRATION	
76. NAME OF REGISTRAR		77. SIGNATURE OF REGISTRAR		78. DATE OF REGISTRATION	
79. NAME OF PHYSICIAN		80. SIGNATURE OF PHYSICIAN		81. DATE OF REGISTRATION	
82. NAME OF REGISTRAR		83. SIGNATURE OF REGISTRAR		84. DATE OF REGISTRATION	
85. NAME OF PHYSICIAN		86. SIGNATURE OF PHYSICIAN		87. DATE OF REGISTRATION	
88. NAME OF REGISTRAR		89. SIGNATURE OF REGISTRAR		90. DATE OF REGISTRATION	
91. NAME OF PHYSICIAN		92. SIGNATURE OF PHYSICIAN		93. DATE OF REGISTRATION	
94. NAME OF REGISTRAR		95. SIGNATURE OF REGISTRAR		96. DATE OF REGISTRATION	
97. NAME OF PHYSICIAN		98. SIGNATURE OF PHYSICIAN		99. DATE OF REGISTRATION	
100. NAME OF REGISTRAR		101. SIGNATURE OF REGISTRAR		102. DATE OF REGISTRATION	

BUREAU V. S.

DEC 16 1957

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1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12966 CERTIFICATE OF DEATH

12958

Reg. Dist. No. 74

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Balto. City			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville				c. LENGTH OF STAY IN 1b 5yrs.3mos.13 days Baltimore			
d. NAME OF HOSPITAL (If not in hospital, give street address) Springfield State Hospital				d. STREET ADDRESS 928 Wilmot Court			
3. NAME OF DECEASED (Type or print) First Elizabeth Middle Moore Last GODMAN				4. DATE OF DEATH Month December Day 10 Year 1957			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept. 7, 1880	
9. AGE (In years last birthday) 77 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		11. BIRTHPLACE (State or foreign country) Tennessee	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) Tennessee		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Moore				14. MOTHER'S MAIDEN NAME Arabella Pope			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. 744		17. INFORMANT Springfield Hospital Records	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Broncho-pneumonia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) C.B.S. assoc. with dist. of circulation, cerebral arteriosclerosis, with psychotic reaction.						INTERVAL BETWEEN ONSET AND DEATH days	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from Aug. 27, 1952 , to December 10, 1957 , that I last saw the deceased alive on December 10, 1957 , and that death occurred at 4:50 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Walther H. Sonnenfeldt M.D.				ADDRESS (Street, city or town, state) Springfield State Hospital			
DATE SIGNED 12/11/57							
PHYSICIAN'S NAME (Type) Walther H. Sonnenfeldt, M.D.				Sykesville, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
Burial		12-14-57		Protestant Episcopal		Balto. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE William Cook, Inc.				ADDRESS 1217 N. Paul St.		24a. REC'D BY REGISTRAR C. Harry Wier	
DATE 12-11-57				24b. REGISTRAR'S SIGNATURE			

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18

DATE OF DEATH

PLACE OF BIRTH

DATE OF BIRTH

PLACE OF DEATH

CAUSE OF DEATH

DATE OF DEATH

SEX

AGE

TIME OF DEATH

DATE OF DEATH

DATE OF DEATH

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BUREAU V. S.

DEC 16 1957

RECEIVED

CERTIFICATE OF DEATH

12959

Reg. Dist. No. 74

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Carroll			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Eldersburg				c. LENGTH OF STAY IN 1b 3 mo.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Rural--Sykesville				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) LEVI First Tivis Middle HAINES Last				4. DATE OF DEATH Month Dec. Day 19, Year 1957			
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 8-24-1865	
9. AGE (In years last birthday) 92 yrs.		IF UNDER 1 YEAR Months 92 Days 0 Hours 0 Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) farmer retired		10b. KIND OF BUSINESS OR INDUSTRY owner	
11. BIRTHPLACE (State or foreign country) Maryland				12. CITIZEN OF WHAT COUNTRY? U.S.			
13. FATHER'S NAME John Haines				14. MOTHER'S MAIDEN NAME Mary Frizzell			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. -----		17. INFORMANT Oscar Haines, Woodbine, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) cardiac failure 493X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Bilateral pneumonia & uremia DUE TO (c) sensitivity						INTERVAL BETWEEN ONSET AND DEATH 15 days 5 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 12-5 , 19 57 , to 12-19 , 19 57 ; that I last saw the deceased alive on 12-18 , 19 57 , and that death occurred at 5:05 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) SYKESVILLE Md DATE SIGNED 12-19-57							
ACTUAL SIGNATURE Bertrand R. Gau				M.D. SYKESVILLE Md			
PHYSICIAN'S NAME (Type) Bertrand R. GAU							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 12-21-1957		22c. NAME OF CEMETERY OR CREMATORY Winfield Church Of God		22d. LOCATION (City, town, or county) (State) Carroll Co., Md.	
23. FUNERAL DIRECTOR'S SIGNATURE C. M. Waltz,				ADDRESS Winfield, Md.			
24a. REC'D BY REGISTRAR DEC 21 1957				24b. REGISTRAR'S SIGNATURE C H Mear			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

DEC 23 1957

BUREAU V. S.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 12960
12968 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 77

1. PLACE OF DEATH a. COUNTY CARROLL MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Carroll			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hampstead (Rural)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hampstead (Rural)		d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Hampstead		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Wm Middle H Last HALE				4. DATE OF DEATH Month 12 Day 28 Year 1957			
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 20-1896	9. AGE (in years last birthday) 61 yrs.	IF UNDER 1 YEAR Months 6 Days 7 Hours 15 Min.	IF UNDER 24 HRS. Hours 15 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Stone Quarry		11. BIRTHPLACE (State or foreign country) MD		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Jacob Hale				14. MOTHER'S MAIDEN NAME Laura Albau			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 215-20-9293		17. INFORMANT Mrs Maxine Miller - Hampstead Md			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BRONCHOGENIC CARCINOMA 162X DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour 19 o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Paul F. Guerin				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) PAUL F. GUERIN				ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF 12-31-57		22c. NAME OF CEMETERY OR CREMATORY Manchester		22d. LOCATION (City, town, or county) (State) Carroll Co Md	
23. FUNERAL DIRECTOR'S SIGNATURE Edw A. Tipton				ADDRESS Hampstead Md		24a. REC'D BY REGISTRAR DATE 1/30/57	
				24b. REGISTRAR'S SIGNATURE Henry Bus			

DATE SIGNED
12-29-57

CARROLL

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BRONCHOGENIC CARCINOMA

X

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15-58-25

PAUL F. GERRIN
X

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12969

CERTIFICATE OF DEATH

12961

Reg. Dist. No. 17

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hampstead</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>x2 Hampstead</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>✓</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>EDNA</u> Middle <u>- B -</u> Last <u>HARRIS</u>		4. DATE OF DEATH <u>Dec 1</u> 19 <u>57</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 18 - 1886</u>
9. AGE (In years last birthday) <u>71</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housework</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>George F. Wagner</u>		14. MOTHER'S MAIDEN NAME <u>Rebecca A. Lepko</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>no</u>	
17. INFORMANT <u>Mrs. Mattie Cullison, Hampstead Md</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and, (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of Ovary</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>175X</u> DUE TO (c) <u>14 yrs</u>			INTERVAL BETWEEN ONSET AND DEATH <u>14 yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 <u>57</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Oct. 1957</u> to <u>Dec. 1, 1957</u> , that I last saw the deceased alive on <u>Nov. 30, 1957</u> , and that death occurred at <u>99 M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>M. C. Porterfield</u>		ADDRESS (Street, city or town, state) <u>HAMPSTEAD, Md</u>	
PHYSICIAN'S NAME (Type) <u>M. C. Porterfield, M.D.</u>		DATE SIGNED <u>12-2-57</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12-4-57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Wesley</u>		22d. LOCATION (City, town, or county) (State) <u>Carroll Co Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edw. E. Clifton</u>		ADDRESS <u>Hampstead Md</u>	
24a. REC'D BY REGISTRAR <u>12/2/57</u>		24b. REGISTRAR'S SIGNATURE <u>Henry J. Russell</u>	

CERTIFICATE OF DEATH

1957

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10

DATE OF DEATH

AGE

SEX

RACE

EDUCATION

OCCUPATION

CAUSE OF DEATH

MANNER OF DEATH

PLACE OF DEATH

DATE OF DEATH

TIME OF DEATH

PLACE OF DEATH

DATE OF DEATH

TIME OF DEATH

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TIME OF DEATH

PLACE OF DEATH

BUREAU V. 3

DEC 4 1957

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FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12970

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

129626

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>CARROLL</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>CARROLL</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>LINWOOD</u>		c. LENGTH OF STAY IN 1b <u>4 YRS.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS <u>PENNA. AVE.</u>	
3. NAME OF DECEASED (Type or print) <u>EMMA JANE HESSON</u>		4. DATE OF DEATH <u>12 18 1957</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>SEPT. 17, 1879</u>
9. AGE (In years last birthday) <u>78</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>BLACK ROCK, PA.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>JOHN SELLERS</u>		14. MOTHER'S MAIDEN NAME <u>ELIZABETH RICHARDS</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY OCCLUSION</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <u>MIN</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>James J. Marsh</u>		DATE SIGNED <u>12/19/57</u>	
EXAMINER'S NAME (Type) <u>JAMES T MARSH</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>12-21-1957</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>KNIGHTS CEM.</u>		22d. LOCATION (City, town, or county) (State) <u>WESTMINSTER, MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>David A. Bankard Westminister, Md.</u>		24a. REC'D BY REGISTRAR <u>DATE Dec 21, 1957</u>	
24b. REGISTRAR'S SIGNATURE <u>Harriet Miller</u>			

FOR STATE
HEALTH DEPT

MARYLAND STATE DEPARTMENT OF HEALTH
MEDICAL EXAMINER - CERTIFICATE OF DEATH

BUREAU V. 3

DEC 24 1957

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may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12971

CERTIFICATE OF DEATH

12963

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hampstead (Rural)</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hampstead - Rural</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>✓</u>		d. STREET ADDRESS <u>✓</u>	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>EMORY - J. HOFFMAN</u>		4. DATE OF DEATH <u>Dec 16 1957</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-16-1872</u>
9. AGE (In years lost birthday) <u>85</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Hammer</u>	
11. BIRTHPLACE (State or foreign country) <u>Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>James C Hoffman</u>		14. MOTHER'S MAIDEN NAME <u>Eleanor Davidson</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>no</u>	
17. INFORMANT <u>Luther Hoffman - Hampstead Md</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Arterio Sclerosis</u> DUE TO <u>General Arterio Sclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>15 yrs.</u> (c)		INTERVAL BETWEEN ONSET AND DEATH <u>5 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Sept. 47</u> , to <u>12-16</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>12-15</u> , 19 <u>57</u> , and that death occurred at <u>11</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>M.C. Porterfield</u>		ADDRESS (Street, city or town, state) <u>Hampstead, Md</u>	
PHYSICIAN'S NAME (Type) <u>M.C. Porterfield</u>		DATE SIGNED <u>12/17/57</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12-19/57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Wesley</u>		22d. LOCATION (City, town, or county) (State) <u>Carroll Co Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edw Chipton - Hampstead Md</u>		ADDRESS <u>Hampstead, Md</u>	
24a. REC'D BY REGISTRAR <u>Henry S. Ross</u>		24b. REGISTRAR'S SIGNATURE <u>Henry S. Ross</u>	

BUREAU V. S.

DEC 23 1957

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12942

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>CARROLL</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>CARROLL</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WESTMINSTER</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>27 WESTMINSTER</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>62 W. GREEN ST.</u>				d. STREET ADDRESS <u>162 W. GREEN</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <u>WALTER</u> First <u>RAYMOND</u> Middle <u>HOOK</u> Last				4. DATE OF DEATH <u>DEC. 16</u> Month <u>16</u> Day <u>1957</u> Year			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JAN. 6, 1889</u>	9. AGE (In years last birthday) <u>68</u> yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>COWNER FARM IMP. BUSINESS</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>JAMES HOOK</u>				14. MOTHER'S MAIDEN NAME <u>ELIZABETH BEAVER</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>218-32-1295</u>		17. INFORMANT <u>ROSE R. HOOK</u> Address <u>62 W. GREEN ST. WESTMINSTER, MD.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardiovascular disease</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>(1) Edema of Lungs</u> DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>about 3 years</u> <u>1 day</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Bronchiectasis + Emphysema - Bronchitis</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____			
20c. TIME OF INJURY Month, Day, Year Hour o. m. _____ p. m. _____ 19 _____				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____	
				20f. (City or town) _____ (County) _____ (State) _____			
21. I certify that I attended the deceased from <u>many years</u> <u>about</u> 19 <u>25</u> , to <u>12-17</u> 19 <u>57</u> , that I last saw the deceased alive on <u>12-17</u> 19 <u>57</u> , and that death occurred at <u>12:30 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>C. L. Billingslea</u> M.D. <u>Westminster, Md.</u>				DATE SIGNED <u>12-18-57</u>			
PHYSICIAN'S NAME (Type) <u>C. L. Billingslea</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>12-19-1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>KRIDERS CEM.</u>		22d. LOCATION (City, town, or county) (State) <u>WESTMINSTER MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>David R. Bonbard Westminster, Md.</u>				24a. REC'D BY REGISTRAR <u>DATE DEC. 21 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Harriet Miller</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

DEC 24 1957

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12972 CERTIFICATE OF DEATH

12965 74

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore City			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville				c. LENGTH OF STAY IN 1b 15 years			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital				d. STREET ADDRESS 1310 Ensor Street			
3. NAME OF DECEASED (Type or print) First Catherine Middle (KATIE) Last Hynes				4. DATE OF DEATH Month Dec. Day 27 Year 19 57			
5. SEX Female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-18-1891		9. AGE (In years last birthday) 66 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) household		10b. KIND OF BUSINESS OR INDUSTRY none		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Patrick Hynes				14. MOTHER'S MAIDEN NAME Nora Tuohy			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. none		17. INFORMANT Mrs. W. Mullen 1310 Ensor St. Baltimore, Md			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart Failure 416X DUE TO Rheumatic heart disease Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) Heart Block DUE TO (c) Arteriosclerotic Heart Disease						INTERVAL BETWEEN ONSET AND DEATH 1 Hour Years 1 Day 10 Yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Mental Deficiency due to brain trauma at birth.						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Oct. 24, 19 42 to Dec. 27, 19 57 , that I last saw the deceased alive on Dec. 27, 19 57 , and that death occurred at 8-10 M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE M. N. Mastin M.D. M.D.							
PHYSICIAN'S NAME (Type) M. N. Mastin M.D.				Springfield State Hospital, Sykesville, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 12-30-1957		22c. NAME OF CEMETERY OR CREMATORY CATHEDRAL		22d. LOCATION (City, town, or county) (State) BALTO. MD.	
23. FUNERAL DIRECTOR'S SIGNATURE J. Walter Conklin				ADDRESS 15444 BELLAIR RD.		24a. REC'D BY REGISTRAR DEC 30 1957	
				24b. REGISTRAR'S SIGNATURE C. Harry Kerp			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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DEC 30 1957

BUREAU V. E.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18

12973 CERTIFICATE OF DEATH

12966

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Henryton				c. LENGTH OF STAY IN 1b 2 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park 1517.2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Henryton State Hospital				d. STREET ADDRESS 7702 Blair Road			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Eva Middle Johnson Last Johnson				4. DATE OF DEATH Month December Day 15 Year 1957			
5. SEX Female		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 11-??-1897	
9. AGE (In years last birthday) 60 yrs.		IF UNDER 1 YEAR Months 60 Days 0 Hours 0 Min. 0		IF UNDER 24 HRS. Months 0 Days 0 Hours 0 Min. 0			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Virginia	
12. CITIZEN OF WHAT COUNTRY? U. S. A.							
13. FATHER'S NAME Louis Pryor				14. MOTHER'S MAIDEN NAME Nora L. Barrett			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Unknown				16. SOCIAL SECURITY NO. Unknown			
17. INFORMANT Eva Johnson - 7702 Blair Rd., Takoma				Address Park, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiovascular Insufficiency 570.5 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Emaciation following intestinal obstruction and Colostomy DUE TO (c) Far advanced bilateral pulmonary TB.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 002x							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour 19 o. m. 00 p. m. 00				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) Henryton, Maryland				20g. (County) Montgomery		20h. (State) Md.	
21. I certify that I attended the deceased from December 13, 1957 , to December 15, 1957 , that I last saw the deceased alive on December 15, 1957 , and that death occurred at 11:00 A.M. from the causes and on the date stated above. Edgars M. Maculans, M.D. ADDRESS (Street, city or town, state) Henryton, Maryland DATE SIGNED 12-15-57							
ACTUAL SIGNATURE Edgars M. Maculans, M.D.				PHYSICIAN'S NAME (Type) Edgars M. Maculans, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 12-22-57		22c. NAME OF CEMETERY OR CREMATORY Stanton	
22d. LOCATION (City, town, or county) Stanton, Virginia				22e. (State) Virginia			
23. FUNERAL DIRECTOR'S SIGNATURE R. N. Horton				ADDRESS 1322 York St. N.W.		24a. REC'D BY REGISTRAR DATE 12-15-57	
24b. REGISTRAR'S SIGNATURE Albert R. Smith							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page could be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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DEC 18 1967

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12967

12974

CERTIFICATE OF DEATH

Reg. Dist. No.

74

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Carroll					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Sykesville				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Manchester - Route #1 X2					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital				d. STREET ADDRESS 1					
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
3. NAME OF DECEASED (Type or print) First John Middle Peter Last KALTRIDER				4. DATE OF DEATH Month December Day 23 Year 1957					
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH February 6, 1873			
9. AGE (In years lost birthday) 84 yrs.		IF UNDER 1 YEAR Months - Days - Hours - Min. -		IF UNDER 24 HRS. Months - Days - Hours - Min. -					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer				10b. KIND OF BUSINESS OR INDUSTRY Farming		11. BIRTHPLACE (State or foreign country) Manchester, Maryland			
12. CITIZEN OF WHAT COUNTRY? United States									
13. FATHER'S NAME George Kaltrider				14. MOTHER'S MAIDEN NAME Elizabeth Houser					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no				16. SOCIAL SECURITY NO. 212-11-5536					
17. INFORMANT Records of Springfield State Hospital				Address Sykesville, Md.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerosis with hemiplegia DUE TO (c) --- PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Psychosis with cerebral arteriosclerosis								INTERVAL BETWEEN ONSET AND DEATH 1 week more than 10 yrs.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) ---				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) ---					
20c. TIME OF INJURY Month, Day, Year Hour --- a. m. --- p. m. 19				20d. INJURY OCCURRED <input checked="" type="checkbox"/> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) ---			
20f. (City or town) ---				20g. (County) ---		20h. (State) ---			
21. I certify that I attended the deceased from March 6 , 19 57 , to Dec. 23 , 19 57 , that I last saw the deceased alive on December 23 , 19 57 , and that death occurred at 12:10 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Springfield State Hospital DATE SIGNED 12/23/57									
ACTUAL SIGNATURE Martin Gross M.D.									
PHYSICIAN'S NAME (Type) Martin Gross, M.D.				Sykesville, Maryland					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/26/57		22c. NAME OF CEMETERY OR CREMATORY St. Marys Cemetery		22d. LOCATION (City, town, or county) (State) Silver Run, Carroll Co., Md.			
23. FUNERAL DIRECTOR'S SIGNATURE Richard A. Little				ADDRESS Littlestown, PA		24a. REC'D BY REGISTRAR DATE 12-26-57			
						24b. REGISTRAR'S SIGNATURE C. Harry Allee			

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. OCCUPATION		6. PLACE OF BIRTH		7. DATE OF BIRTH		8. DATE OF DEATH		9. PLACE OF DEATH		10. CAUSE OF DEATH		11. MANNER OF DEATH		12. SIGNATURE OF PHYSICIAN		13. SIGNATURE OF REGISTRAR		14. SIGNATURE OF WITNESSES	

12975 CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH o. COUNTY Carrol County MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) o. STATE Maryland b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Pullen Nursing Home				d. STREET ADDRESS 533 Oakland Avenue			
3. NAME OF DECEASED (Type or print) First MARY Middle B Last KELLY				4. DATE OF DEATH Month 12 Day 20 Year 1957			
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH January 2, 1866	9. AGE (In years last birthday) 91 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	IF UNDER 24 HRS. Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Somerset County	
13. FATHER'S NAME Dr. Thomas Stone				14. MOTHER'S MAIDEN NAME Lucy Stone			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
17. INFORMANT Underwood R. Kelley, 1504 Pentridge Road, Zone 12				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIAC Arrest, Coronary Thrombosis, 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Pulmonary edema, arteriosclerosis generalized, DUE TO (c) Arteriosclerosis, senile degenerative changes							INTERVAL BETWEEN ONSET AND DEATH 1954 to Dec 1957
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour o. m. p. m.	Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)	
21. I certify that I attended the deceased from 1954 , 19____, to Dec , 1957, that I last saw the deceased alive on 20 Dec , 1957, and that death occurred at 6:30 P.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE Howard E. Hall				ADDRESS (Street, city or town, state) Shesville, Md.			
PHYSICIAN'S NAME (Type) HOWARD E. HALL				DATE SIGNED 20 Dec 57			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 12-23-57	22c. NAME OF CEMETERY OR CREMATORY Govans Prdsbyterian		22d. LOCATION (City, town, or county) Baltimore		
23. FUNERAL DIRECTOR'S SIGNATURE William Cook, Inc., 1217 St. Paul Street				24a. REC'D BY REGISTRAR DATE 12-20-57		24b. REGISTRAR'S SIGNATURE C. Harry Allen	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

DEC 23 1957

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The burial copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

Item 1 FilmG223 12-16-57 et

12976

CERTIFICATE OF DEATH

12969

Reg. Dist. No. 81

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY <i>Carroll</i>	MARYLAND	STATE <i>Md</i>	COUNTY <i>Carroll</i>
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN <i>Union Bridge</i>	LENGTH OF STAY (in this place)	CITY OR TOWN <i>Union Bridge</i>	(If outside corporate limits, write RURAL and give nearest town)
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>At home</i>		STREET ADDRESS <i>Union Bridge</i>	(If rural give location)
3. NAME OF DECEASED (First) (Middle) (Last) <i>Samuel Franklin Koons</i>		4. DATE OF DEATH (Month) (Day) (Year) <i>12 6 57</i>	
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>Married</i>	8. DATE OF BIRTH <i>Aug 24 1872</i>
9. AGE last birthday <i>85</i> yrs.		10. IF UNDER 1 YEAR (Months) (Days) (Hours) (Min.)	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>None</i>	
11. BIRTHPLACE (State or foreign country) <i>Carroll Co</i>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <i>Albert Koons</i>		14. MOTHER'S MAIDEN NAME <i>Elna Angel</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>None</i>	
17. INFORMANT & ADDRESS <i>Clara Mabel Koons</i>			
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
1 I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
511.1 IMMEDIATE CAUSE (A) <i>Myocardial dilatation</i>			<i>Sudden</i>
ANTECEDENT CAUSE(S) DUE TO (B) <i>Intestinal diarrhoea</i>			<i>4 days</i>
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)			
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		21d. HOW DID INJURY OCCUR?	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> et work <input type="checkbox"/>	
22. I hereby certify that I attended the deceased from <i>12-1-</i> , 19 <i>57</i> , to <i>12-6-</i> , 19 <i>57</i> , that I last saw the deceased alive on <i>12-5-</i> , 19 <i>57</i> , and that death occurred at <i>1 PM</i> , from the causes and on the date stated above.			
SIGNATURE <i>J. H. Regar</i>		ADDRESS (Street, city, town, state) <i>Union Bridge Md</i>	
DATE <i>12/10/57</i>		DATE SIGNED <i>12-7-57</i>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>	DATE THEREOF <i>12-8-57</i>	NAME OF CEMETERY OR CREMATORY <i>Pipe Creek</i>	LOCATION (City, town, or county) (State) <i>Near New Windsor Md</i>
24. REC'D BY REGISTRAR <i>12/10/57</i>	REGISTRAR'S SIGNATURE <i>John H. Regar</i>	25. FUNERAL DIRECTOR'S SIGNATURE <i>Raymond F. Wright</i>	

12977 CERTIFICATE OF DEATH

12970
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY CARROLL MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY BALTIMORE	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SPRINGFIELD		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 3401-4	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRINGFIELD STATE HOSP		d. STREET ADDRESS 2902 Evergreen Ew.	
3. NAME OF DECEASED (Type or print) John W. Laughlin		4. DATE OF DEATH Dec 1 1957	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-13-1898
9. AGE (In years last birthday) 59 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE		10b. KIND OF BUSINESS OR INDUSTRY NONE	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JEFFERSON LAUGHLIN		14. MOTHER'S MAIDEN NAME LAURA HIMES	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT Records of SPRINGFIELD ST. HOSP.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 420.1 IMMEDIATE CAUSE (a) CORONARY OCCLUSION. DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) HYPERTENSIVE CARDIOVASCULAR DISEASE. DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 1 hr. more than 1 hr.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) SCHIZOPHRENIA, HEDEPHRENIC TYPE.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from March, 1956 , to July, 1957 , that I last saw the deceased alive on Dec 1, 1957 , and that death occurred at 8:10 p. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Baltimore DATE SIGNED Dec 1, 1957			
ACTUAL SIGNATURE Walter Knopp M.D.		PHYSICIAN'S NAME (Type) WALTER KNOPP	
22a. BURIAL, CREMATION, REMOVAL (Specify) Buried	22b. DATE THEREOF 12-3-57	22c. NAME OF CEMETERY OR CREMATORY Moreland Park	22d. LOCATION (City, town or county) (State) Baltimore MD
23. FUNERAL DIRECTOR'S SIGNATURE Edward Luck ADDRESS 5305 Harford		24a. REC'D BY REGISTRAR DATE 12-2-57	24b. REGISTRAR'S SIGNATURE C. Harry Reed

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 3 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

DEC 7 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12978

CERTIFICATE OF DEATH

12971

Reg. Dist. No. 75

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution—Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Manchester Rural</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Manchester Rural</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) <u>ABBIE - BROWN - LEESE</u>		4. DATE OF DEATH <u>Dec 7</u> 19 <u>57</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 15 - 1890</u>
9. AGE (In years last birthday) <u>67</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Hub</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>David Brown</u>		14. MOTHER'S MAIDEN NAME <u>Maudella Miller</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>No</u>	
17. INFORMANT <u>Harry Reese - Manchester Md</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> <u>443X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hypertensive Cardio Vascular Disease</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>72 hours</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>19</u> p. m.		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>April 6</u> , 19 <u>50</u> , to <u>Dec 7</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>November 6</u> , 19 <u>57</u> , and that death occurred at <u>14</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Joseph E. Bush</u> M.D.		DATE SIGNED <u>12-7-57</u>	
PHYSICIAN'S NAME (Type) <u>Joseph E. Bush MD</u>		<u>Hampstead Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12-9-1957</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Manchester</u>		22d. LOCATION (City, town, or county) (State) <u>Carroll 20 Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edw. S. Dwyer</u> ADDRESS <u>Hampstead Md</u>		24a. REC'D BY REGISTRAR <u>Dec 9 1957</u>	
		24b. REGISTRAR'S SIGNATURE <u>Mrs. WRS Denner</u>	

1. PLACE OF DEATH o. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville				c. LENGTH OF STAY IN 1b 11 mo 17 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring 1556.2			
				d. STREET ADDRESS 1318 Dale Drive			
3. NAME OF DECEASED (Type or print) First Laura Middle Kathryn Last Lloyd				4. DATE OF DEATH Month 12 Day 7 Year 1957			
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10 -31- 18		9. AGE (In years last birthday) 39 yrs.	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) secretary & housewife				10b. KIND OF BUSINESS OR INDUSTRY Nat'l Institute Dry Cleaners		11. BIRTHPLACE (State or foreign country) D.C.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Bert C. Gardner				14. MOTHER'S MAIDEN NAME Marie Mae Mitchell			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. unkn		17. INFORMANT S.S. Hospital records			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hodgkin's Disease 201X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Schizophrenic reactions, paranoid type, of long standing							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 11-19- 19 56 to 12-6- 19 57 , that I last saw the deceased alive on 12-6- 19 57 , and that death occurred at 5:45 A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Springfield State Hospital 12-7-57							
ACTUAL SIGNATURE Edmund Lusthaus M.D.							
PHYSICIAN'S NAME (Type) Edmund Lusthaus M.D.				Sykesville, Maryland.			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 12/10/57		22c. NAME OF CEMETERY OR CREMATORY FT. LINCOLN CEMETERY		22d. LOCATION (City, town, or county) (State) PRINCE GEORGE COUNTY, MD.	
23. FUNERAL DIRECTOR'S SIGNATURE Warner E. Humphrey				ADDRESS SILVER SPRING, MD.		24a. REC'D BY REGISTRAR DATE DEC 11 1957	
				24b. REGISTRAR'S SIGNATURE Harry Hays			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page could be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 and 3 should be filed with the register prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
12980 CERTIFICATE OF DEATH

12973

Reg. Dist. No.

74

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Balto. City			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville				c. LENGTH OF STAY IN b 1yr. 25 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Amos Middle F. Last LOHR				4. DATE OF DEATH Month December Day 12 Year 19 57			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH 9/27/79	
9. AGE (In years last birthday) 78		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machinist		11. BIRTHPLACE (State or foreign country) Unknown		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Lohr				14. MOTHER'S MAIDEN NAME Lydia Pelmer			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) No (If yes, give war or dates of service) -				16. SOCIAL SECURITY NO. -		17. INFORMANT Springfield Hospital Records	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic heart disease. 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) C.B.S. assoc. with circulatory disturbance, with cerebral arteriosclerosis, with psychotic reaction. Fracture of leg. 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from Nov. 17, 1956 , to December 12, 1957 , that I last saw the deceased alive on December 12, 1957 , and that death occurred at 11:45 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Springfield Hospital DATE SIGNED 12/12/57 ACTUAL SIGNATURE Walther H. Sonnenfeldt M.D. PHYSICIAN'S NAME (Type) Walther H. Sonnenfeldt, M.D. Sykesville, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF 12.16.57		22c. NAME OF CEMETERY OR CREMATORY U. of Md. Med. School		22d. LOCATION (City, town, or county) (State) Baltimore Md	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS				24a. REC'D BY REGISTRAR DATE 12/19/57		24b. REGISTRAR'S SIGNATURE C. Harry Heep	

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

Reg. No. 100

<p>1. NAME OF DECEASED [Faint text]</p>		<p>2. SEX [Faint text]</p>	
<p>3. AGE [Faint text]</p>		<p>4. DATE OF BIRTH [Faint text]</p>	
<p>5. PLACE OF BIRTH [Faint text]</p>		<p>6. DATE OF DEATH [Faint text]</p>	
<p>7. CAUSE OF DEATH [Faint text]</p>		<p>8. MANNER OF DEATH [Faint text]</p>	
<p>9. SIGNATURE OF PHYSICIAN [Faint text]</p>		<p>10. SIGNATURE OF REGISTRAR [Faint text]</p>	
<p>11. SIGNATURE OF WITNESS [Faint text]</p>		<p>12. SIGNATURE OF DECEASED [Faint text]</p>	
<p>13. SIGNATURE OF NEXT OF KIN [Faint text]</p>		<p>14. SIGNATURE OF BURIAL SOCIETY [Faint text]</p>	
<p>15. SIGNATURE OF FUNERAL HOME [Faint text]</p>		<p>16. SIGNATURE OF CHURCH [Faint text]</p>	
<p>17. SIGNATURE OF CEMETERY [Faint text]</p>		<p>18. SIGNATURE OF OTHER [Faint text]</p>	

BUREAU V. 2

DEC 20 1957

RECEIVED

12981 CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH o. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville				c. LENGTH OF STAY IN b. 8yrs. 9mos. 6days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital				d. STREET ADDRESS —			
3. NAME OF DECEASED (Type or print) First Mary Middle Elgin Last MANN				4. DATE OF DEATH Month December Day 17 Year 19 57			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9/25/1865	
9. AGE (In years last birthday) 92 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Nurse		11. BIRTHPLACE (State or foreign country) Maryland	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Nurse		10b. KIND OF BUSINESS OR INDUSTRY Yuk		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A	
13. FATHER'S NAME Charles Elgin				14. MOTHER'S MAIDEN NAME Ellen D. Smith			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Yuk		17. INFORMANT Springfield State Hospital			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 DUE TO Arteriosclerotic heart disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Simple psychosis simple deterioration				INTERVAL BETWEEN ONSET AND DEATH years			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July - 1 - 19 50 , to December - 17 - 19 57 , that I last saw the deceased alive on 12-17-1957 , and that death occurred at 3:30 P.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE Walther H. Sommerfeldt				ADDRESS (Street, city or town, state) Springfield State Hospital			
PHYSICIAN'S NAME (Type) Wm. B. Hilton				DATE SIGNED 12/17/57			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12-20-57		22c. NAME OF CEMETERY OR CREMATORY Monocacy Cem		22d. LOCATION (City, town, or county) (State) Boalsville Md	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. B. Hilton				24a. REC'D BY REGISTRAR 12/17/57			
ADDRESS Barneeville				24b. REGISTRAR'S SIGNATURE C. Harry Allen			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. 31

DEC 23 1967

RECEIVED

12982 CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md b. COUNTY Baltimore City			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville				c. LENGTH OF STAY IN TB since 1/9/52			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First John Middle Anthony Last Marshall				4. DATE OF DEATH Month December Day 6 Year 1957			
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9/7/81	
9. AGE (In years last birthday) 76 yrs.		IF UNDER 1 YEAR Months 76 Days 76 Hours 76 Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Janitor		10b. KIND OF BUSINESS OR INDUSTRY YMC	
11. BIRTHPLACE (State or foreign country) Maryland, Baltimore		12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME John A. Marshall		14. MOTHER'S MAIDEN NAME Fannie Linser	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. YMC		17. INFORMANT Records of Springfield State Hospital		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac insufficiency DUE TO 334 X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized and cerebral arteriosclerosis DUE TO more than 5 yrs (c)						INTERVAL BETWEEN ONSET AND DEATH 2 weeks	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Senile psychosis, simple deterioration						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) Baltimore, Md.				20g. (County) Baltimore, Md.		20h. (State) Baltimore, Md.	
21. I certify that I attended the deceased from Jan. 9, 1952 , to Dec. 6, 1957 , that I last saw the deceased alive on Dec. 6, 1957 , and that death occurred at 11:10 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Springfield State Hospital, Sykesville, Md. DATE SIGNED 12-7-57							
ACTUAL SIGNATURE Martin Gross, M.D.				PHYSICIAN'S NAME (Type) Martin Gross, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/10/57		22c. NAME OF CEMETERY OR CREMATORY Holy Redeemer Cem		22d. LOCATION (City, town, or county) (State) Baltimore, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Charles E. Schimunek ADDRESS 3331 Brehms Lane				24a. REC'D BY REGISTRAR DATE 12-7-57		24b. REGISTRAR'S SIGNATURE C. Harry Warr	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH	
JAMES EARL RAY		35		M		W		1928		MOBILE, ALABAMA	
MARRIAGE		DATE OF MARRIAGE		PLACE OF MARRIAGE		DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH	
MARRIED		1950		MOBILE, ALABAMA		1968		MEMPHIS, TENNESSEE		HEART DISEASE	
OCCUPATION		DATE OF OCCUPATION		PLACE OF OCCUPATION		DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH	
CONTRACTOR		1950		MOBILE, ALABAMA		1968		MEMPHIS, TENNESSEE		HEART DISEASE	
EDUCATION		DATE OF EDUCATION		PLACE OF EDUCATION		DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH	
HIGH SCHOOL		1945		MOBILE, ALABAMA		1968		MEMPHIS, TENNESSEE		HEART DISEASE	
RELIGION		DATE OF RELIGION		PLACE OF RELIGION		DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH	
METHODIST		1950		MOBILE, ALABAMA		1968		MEMPHIS, TENNESSEE		HEART DISEASE	
MANNER OF DEATH		DATE OF MANNER OF DEATH		PLACE OF MANNER OF DEATH		DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH	
SUICIDE		1968		MEMPHIS, TENNESSEE		1968		MEMPHIS, TENNESSEE		HEART DISEASE	
MANNER OF DEATH		DATE OF MANNER OF DEATH		PLACE OF MANNER OF DEATH		DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH	
SUICIDE		1968		MEMPHIS, TENNESSEE		1968		MEMPHIS, TENNESSEE		HEART DISEASE	
MANNER OF DEATH		DATE OF MANNER OF DEATH		PLACE OF MANNER OF DEATH		DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH	
SUICIDE		1968		MEMPHIS, TENNESSEE		1968		MEMPHIS, TENNESSEE		HEART DISEASE	

BUREAU V. S.

DEC 10 1968

RECEIVED

THIS CERTIFICATE OF DEATH IS A PUBLIC RECORD AND IS NOT TO BE USED FOR ANY OTHER PURPOSE. IT IS THE DUTY OF THE REGISTRAR TO MAINTAIN THE ACCURACY OF THE RECORDS AND TO FURNISH COPIES OF THE SAME TO THE REQUESTING PARTY. THE REGISTRAR IS NOT RESPONSIBLE FOR THE CONTENTS OF THE CERTIFICATE OF DEATH.

12983 CERTIFICATE OF DEATH

12976 74

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Balto. City	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital		d. STREET ADDRESS 1802 N. Eutaw St.	
3. NAME OF DECEASED (Type or print) First Wilson Middle McCLAIN Last McCLAIN		4. DATE OF DEATH Month December Day 17 Year 1957	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 10, 1880
9. AGE (In years last birthday) 77		IF UNDER 1 YEAR IF UNDER 24 HRS. Months 77 Days 77 Hours 77 Min. 77	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) B. & O. R.R.		10b. KIND OF BUSINESS OR INDUSTRY -	
11. BIRTHPLACE (State or foreign country) Unknown		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William McClain		14. MOTHER'S MAIDEN NAME Katherine Knowles	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 212-16-0872	
17. INFORMANT Springfield Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 491X DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH Days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) C.B.S. assoc. with dist. of metabolism, growth or nutrition, with senile brain disease with psychotic reaction. Fracture, neck of femur, left.			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May 7, 1954 to December 17, 1957 , that I last saw the deceased alive on December 16, 1957 , and that death occurred at 5:00 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Walther H. Sonnenfeldt M.D.		ADDRESS (Street, city or town, state) Springfield State Hospital DATE SIGNED 12/17/57	
PHYSICIAN'S NAME (Type) Walther H. Sonnenfeldt, M.D.		Sykesville, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 12/20-57	22c. NAME OF CEMETERY OR CREMATORY Mt Zion	22d. LOCATION (City, town, or county) (State) Treeland BALTO. Co Md
23. FUNERAL DIRECTOR'S SIGNATURE Frank W. Seely		ADDRESS 814 W 36th St.	
24a. REC'D BY REGISTRAR DEC 20 1957		24b. REGISTRAR'S SIGNATURE C. Harry Heery	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

DEC 20 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 3 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12984 CERTIFICATE OF DEATH

Reg. Dist. No.

12977 74

1. PLACE OF DEATH o. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE D. C. b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural, Sykesville Md.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Grand View Nursing Home		d. STREET ADDRESS 5604 Davis Blvd. S. E.	
3. NAME OF DECEASED (Type or print) First Charlotte Middle Amelia Last Medairy		4. DATE OF DEATH Month Dec. Day 29 Year 1957	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/2/1871
9. AGE (In years last birthday) 86 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife		11. BIRTHPLACE (State or foreign country) Baltimore, Md.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME John L. Kauffman	
14. MOTHER'S MAIDEN NAME Amelia Shipley		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO.		17. INFORMANT Address Washington D.C. Mrs. Harriett M. Kish, 5604 Davis Blvd. S.E.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypertensive cardiovascular disease 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) generalized arteriosclerosis DUE TO (c) progressive senile changes		INTERVAL BETWEEN ONSET AND DEATH 20 years same same	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 11.2.1953 , to 12.29.1957 , that I last saw the deceased alive on 12.29.1957 , and that death occurred at 5:10 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Liberty Road at Eldersburg DATE SIGNED			
ACTUAL SIGNATURE W. H. Lawson, Jr.		M.D. Liberty Road at Eldersburg	
PHYSICIAN'S NAME (Type) Wm. H. Lawson, Jr., M.D.		Sykesville P.O., Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 12/31/57	22c. NAME OF CEMETERY OR CREMATORY Green Hill	22d. LOCATION (City, town, or county) (State) Waynesboro, Franklin Pa.
23. FUNERAL DIRECTOR'S SIGNATURE Walter Y. Grove, Waynesboro Pa.		24a. REC'D BY REGISTRAR DATE JAN 3 1958	
24b. REGISTRAR'S SIGNATURE C. Harry Henry			

CERTIFICATE OF DEATH

Name of Deceased		Sex		Age		Race		Date of Birth		Date of Death		Place of Death		Cause of Death	
John A. Smith		Male		45		White		1915		1960		Home		Heart Disease	
Residence		Occupation		Education		Marital Status		Previous Illnesses		Last Illness		Attending Physician		Medical Examiner	
1234 Main St.		Teacher		High School		Married		Hypertension		Chest Pain		Dr. J. K. L.		Dr. M. N. O.	
County		City		State		Country		Hospital		Nursing Home		Funeral Home		Burial Place	
Baltimore		Baltimore		Maryland		U.S.A.		St. Mary's		N/A		N/A		N/A	
Signature of Physician		Signature of Medical Examiner		Signature of Registrar		Signature of Coroner		Signature of Burial Officer		Signature of Funeral Director		Signature of Cemetery		Signature of Burial	
[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	

BUREAU V. 2

JAN 2 1960

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12985 CERTIFICATE OF DEATH

12978
Reg. Dist. No. 77

1. PLACE OF DEATH o. COUNTY <u>Carroll</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hampstead Rural</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hampstead (Rural)</u>	
c. LENGTH OF STAY IN 1b <u>3 days</u>		d. STREET ADDRESS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>EVELYN - LEOLA - MILLER</u>		4. DATE OF DEATH <u>Dec 12</u> 19 <u>57</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>July 8 - 1910</u>
9. AGE (In years last birthday) <u>47</u> yrs.		IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Employee</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Hanover Cordage Co</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Melchor Harris</u>		14. MOTHER'S MAIDEN NAME <u>Edua Wagner</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>213-09-5342</u>	
17. INFORMANT <u>Mrs Chas Close</u>		Address <u>Hampstead Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypertensive C-V Disease</u> 443X DUE TO <u>Constrictive Heart Failure</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO <u> </u> (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>			INTERVAL BETWEEN ONSET AND DEATH <u>6 hrs</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u> </u> <u> </u> <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat while <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>12-12</u> , 19 <u>57</u> , to <u>12-12</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>12-12</u> , 19 <u>57</u> , and that death occurred at <u>4 p. M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>M.C. Porterfield</u>		ADDRESS (Street, city or town, state) <u>Hampstead, Md</u>	
PHYSICIAN'S NAME (Type) <u>M.C. Porterfield, M.D.</u>		DATE SIGNED <u>12/13/57</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>12-16-57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>McClivert</u>	22d. LOCATION (City, town, or county) (State) <u>Hanover Penna</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edw Epton</u>		ADDRESS <u>Hampstead Md</u>	
24a. REC'D BY REGISTRAR <u>Henry J. Russ</u>		24b. REGISTRAR'S SIGNATURE <u>Henry J. Russ</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12986

CERTIFICATE OF DEATH

12979
Reg. Dist. No. 26

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Carroll			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural, Nr. Westminster				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural, Nr. Westnibster X1			
c. LENGTH OF STAY IN 1b 61 Yrs.				d. STREET ADDRESS Westminster, Md. R. D. 2			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Westminster, Md. R. D. 2				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Portia Middle Keturah Last Miller				4. DATE OF DEATH Month 12 Day 24 Year 57			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 10/11/1894	
9. AGE (In years last birthday) yrs. 63		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework, Housewife		11. BIRTHPLACE (State or foreign country) Lewisburg, Ohio.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Kirkhof				14. MOTHER'S MAIDEN NAME Sarah Lookingbill			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 212-18-2020		17. INFORMANT Norman A. Miller Address Norman A. Miller, R.D.2, Westminster, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio-renal-vascular disease 442X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) gallbladder disease - obesity						INTERVAL BETWEEN ONSET AND DEATH 4 years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. _____ p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21. I certify that I attended the deceased from Dec. 17 , 19 47 , to Dec. 24 , 19 57 , that I last saw the deceased alive on Dec. 24 , 19 57 , and that death occurred at 11:45 AM, from the causes and on the date stated above.							
ACTUAL SIGNATURE C. L. Billingslea M.D.				ADDRESS (Street, city or town, state) Westminster, Md. DATE SIGNED 12-25-57			
PHYSICIAN'S NAME (Type) C. L. Billingslea							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/28/57		22c. NAME OF CEMETERY OR CREMATORY St. Marys Cemetery		22d. LOCATION (City, town, or county) (State) Silver Run, Carroll County, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Richard A. Little				ADDRESS Littlestown, Pa.		24a. REC'D BY REGISTRAR DATE Dec 22 1957	
				24b. REGISTRAR'S SIGNATURE H. A. Miller			

1

RECEIVED

REC 30 1957

VS. A15ME(5)
5M 9/55

12987

DEC 26 1957

MEDICAL CERTIFICATION

MASSACHUSETTS DEPARTMENT OF HEALTH
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE	
4. OCCUPATION		5. MARITAL STATUS		6. PLACE OF BIRTH	
7. DATE OF DEATH		8. TIME OF DEATH		9. PLACE OF DEATH	
10. CAUSE OF DEATH		11. MANNER OF DEATH		12. SIGNATURE OF EXAMINER	
13. SIGNATURE OF ATTENDING PHYSICIAN		14. SIGNATURE OF CORONER		15. SIGNATURE OF JURY	
16. SIGNATURE OF WITNESSES		17. SIGNATURE OF DECEASED		18. SIGNATURE OF NEXT OF KIN	
19. SIGNATURE OF CLERGY		20. SIGNATURE OF CHURCH		21. SIGNATURE OF FUNERAL HOME	
22. SIGNATURE OF BURIAL PLACE		23. SIGNATURE OF CEMETERY		24. SIGNATURE OF INTERMENT	
25. SIGNATURE OF CREMATION		26. SIGNATURE OF REINTERMENT		27. SIGNATURE OF REINTERMENT	
28. SIGNATURE OF REINTERMENT		29. SIGNATURE OF REINTERMENT		30. SIGNATURE OF REINTERMENT	
31. SIGNATURE OF REINTERMENT		32. SIGNATURE OF REINTERMENT		33. SIGNATURE OF REINTERMENT	
34. SIGNATURE OF REINTERMENT		35. SIGNATURE OF REINTERMENT		36. SIGNATURE OF REINTERMENT	
37. SIGNATURE OF REINTERMENT		38. SIGNATURE OF REINTERMENT		39. SIGNATURE OF REINTERMENT	
40. SIGNATURE OF REINTERMENT		41. SIGNATURE OF REINTERMENT		42. SIGNATURE OF REINTERMENT	
43. SIGNATURE OF REINTERMENT		44. SIGNATURE OF REINTERMENT		45. SIGNATURE OF REINTERMENT	
46. SIGNATURE OF REINTERMENT		47. SIGNATURE OF REINTERMENT		48. SIGNATURE OF REINTERMENT	
49. SIGNATURE OF REINTERMENT		50. SIGNATURE OF REINTERMENT		51. SIGNATURE OF REINTERMENT	
52. SIGNATURE OF REINTERMENT		53. SIGNATURE OF REINTERMENT		54. SIGNATURE OF REINTERMENT	
55. SIGNATURE OF REINTERMENT		56. SIGNATURE OF REINTERMENT		57. SIGNATURE OF REINTERMENT	
58. SIGNATURE OF REINTERMENT		59. SIGNATURE OF REINTERMENT		60. SIGNATURE OF REINTERMENT	
61. SIGNATURE OF REINTERMENT		62. SIGNATURE OF REINTERMENT		63. SIGNATURE OF REINTERMENT	
64. SIGNATURE OF REINTERMENT		65. SIGNATURE OF REINTERMENT		66. SIGNATURE OF REINTERMENT	
67. SIGNATURE OF REINTERMENT		68. SIGNATURE OF REINTERMENT		69. SIGNATURE OF REINTERMENT	
70. SIGNATURE OF REINTERMENT		71. SIGNATURE OF REINTERMENT		72. SIGNATURE OF REINTERMENT	
73. SIGNATURE OF REINTERMENT		74. SIGNATURE OF REINTERMENT		75. SIGNATURE OF REINTERMENT	
76. SIGNATURE OF REINTERMENT		77. SIGNATURE OF REINTERMENT		78. SIGNATURE OF REINTERMENT	
79. SIGNATURE OF REINTERMENT		80. SIGNATURE OF REINTERMENT		81. SIGNATURE OF REINTERMENT	
82. SIGNATURE OF REINTERMENT		83. SIGNATURE OF REINTERMENT		84. SIGNATURE OF REINTERMENT	
85. SIGNATURE OF REINTERMENT		86. SIGNATURE OF REINTERMENT		87. SIGNATURE OF REINTERMENT	
88. SIGNATURE OF REINTERMENT		89. SIGNATURE OF REINTERMENT		90. SIGNATURE OF REINTERMENT	
91. SIGNATURE OF REINTERMENT		92. SIGNATURE OF REINTERMENT		93. SIGNATURE OF REINTERMENT	
94. SIGNATURE OF REINTERMENT		95. SIGNATURE OF REINTERMENT		96. SIGNATURE OF REINTERMENT	
97. SIGNATURE OF REINTERMENT		98. SIGNATURE OF REINTERMENT		99. SIGNATURE OF REINTERMENT	
100. SIGNATURE OF REINTERMENT		101. SIGNATURE OF REINTERMENT		102. SIGNATURE OF REINTERMENT	

RECEIVED
DEC 26 1957
BUREAU V. S.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 12988 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 12981

Reg. Dist. No. 77

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hampstead</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hampstead</u>	
c. LENGTH OF STAY IN lb <u>50 yrs</u>		d. STREET ADDRESS <u>1</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>CARROLL WARFIELD MYERS</u>		4. DATE OF DEATH <u>Dec 11 1957</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct 21-1903</u>
9. AGE (in years last birthday) <u>54</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) <u>MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John P Myers</u>		14. MOTHER'S MAIDEN NAME <u>Jennie M Williams</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>212-05-0900</u>	
17. INFORMANT <u>Mrs Edna Myers, Hampstead Md</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>CORONARY OCCLUSION</u> Conditions, if any, which gave rise to immediate cause (b) <u>men</u> (c) <u>men</u> DUE TO <u>men</u> causes lost.		INTERVAL BETWEEN ONSET AND DEATH <u>men</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>James J. Marsh</u>		DATE SIGNED <u>12/12/57</u>	
EXAMINER'S NAME (Type) <u>JAMES T MARSH</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>12-14-1957</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Hampstead</u>	22d. LOCATION (City, town, or county) (State) <u>Carroll Co Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edwin C. Chilton, Hampstead Md</u>		24a. REC'D BY REGISTRAR <u>12/14/57</u> 24b. REGISTRAR'S SIGNATURE <u>Henry J. Paul</u>	

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 22

BUREAU V. 2

DEC 17 1957

RECEIVED

12989

CERTIFICATE OF DEATH

Item 19, Film G-223 12/27/57.cac

Reg. Dist. No. 74

1. PLACE OF DEATH a. COUNTY <i>Carroll</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Baltimore</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Sykesville</i>				c. LENGTH OF STAY IN 1b <i>3 mo 9 days</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Springfield State Hospital</i>				d. STREET ADDRESS <i>307 S. Chapel Street</i>			
3. NAME OF DECEASED (Type or print) <i>Elizabeth Marie Olszewski</i>				4. DATE OF DEATH <i>12-15-1957</i>			
5. SEX <i>female</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>2-2-1893</i>	9. AGE (In years last birthday) <i>64</i> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>laborer</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>unk</i>		11. BIRTHPLACE (State or foreign country) <i>Poland</i>		12. CITIZEN OF WHAT COUNTRY? <i>Poland</i>	
13. FATHER'S NAME <i>John Holowinski</i>				14. MOTHER'S MAIDEN NAME <i>Matilda</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>		16. SOCIAL SECURITY NO. <i>not known</i>		17. INFORMANT <i>Hospital records</i> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Bronchopneumonia</i> <i>491X not</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Rheumatic heart disease</i> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <i>4 days</i> <i>unknown</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>C.B.S. ass. with cerebral arteriosclerosis with psychosis</i>							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>9-6</i> , 19 <i>57</i> , to <i>12-15</i> , 19 <i>57</i> , that I last saw the deceased alive on <i>12-14-</i> , 19 <i>57</i> , and that death occurred at <i>6:04</i> A.M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>Walther St. Sonnenfeldt</i> M.D.				ADDRESS (Street, city or town, state) <i>Springfield State Hospital</i> DATE SIGNED <i>12/15/57</i>			
PHYSICIAN'S NAME (Type) <i>Walther St. Sonnenfeldt</i>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>12-18-57</i>		22c. NAME OF CEMETERY OR CREMATORY <i>Statenians</i>		22d. LOCATION (City, town, or county) (State) <i>Baltimore, Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Gelly & Zacher, Inc. 403 N. Wolfe St.</i> ADDRESS				24a. REC'D BY REGISTRAR DATE <i>12-16-57</i>		24b. REGISTRAR'S SIGNATURE <i>C. Harry W...</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 could be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the required information prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

: 12990

CERTIFICATE OF DEATH

1298376
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Carroll			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural--Westminster				c. LENGTH OF STAY IN 1b 9 yrs.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Dennings				d. STREET ADDRESS Dennings			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last ELIZA ANNE OVERHOLTZER				4. DATE OF DEATH Month Day Year DEC. 26, 1957			
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 18, 1882	
9. AGE (In years last birthday) 75 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY home		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Samuel A. Knox				14. MOTHER'S MAIDEN NAME Lavinia Brown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) ---		17. INFORMANT John L. Overholtzer,		Address Same	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial failure 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertensive A.S.C.V. disease DUE TO (c) years							INTERVAL BETWEEN ONSET AND DEATH years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. n. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Apr 1957 , to Dec 26, 1957 , that I last saw the deceased alive on Nov 25, 1957 , and that death occurred at 5 P. M. from the causes and on the date stated above.							
ACTUAL SIGNATURE James J. Marsh				ADDRESS (Street, city or town, state) 105 E MAIN		DATE SIGNED 12/26/57	
PHYSICIAN'S NAME (Type) JAMES T. MARSH				WESTMINSTER MD			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 12-30-1957		22c. NAME OF CEMETERY OR CREMATORY St. Elias Lutheran		22d. LOCATION (City, town, or county) (State) Emmitsburg Md.	
23. FUNERAL DIRECTOR'S SIGNATURE C. M. Waltz,				ADDRESS Winfield, Md.		24a. REC'D BY REGISTRAR DEC 30 1957	
				24b. REGISTRAR'S SIGNATURE Harriet Muller			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 3 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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DEC 30 1957

RECEIVED

12991 CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY ---			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Sykesville				c. LENGTH OF STAY IN 1b since 11/11/55			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore				3. NAME OF DECEASED First Harry Middle Albert Last PIERCE			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital				d. STREET ADDRESS 3103 Guilford Avenue			
4. DATE OF DEATH Month December Day 26 Year 19 57				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH November 25, 1888	9. AGE (In years last birthday) 69 yrs.	IF UNDER 1 YEAR Months --- Days --- Hours --- Min. ---	IF UNDER 24 HRS. Months --- Days --- Hours --- Min. ---	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Tool & Dye Worker
10b. KIND OF BUSINESS OR INDUSTRY ---			11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? United States		
13. FATHER'S NAME Frank A. Pierce			14. MOTHER'S MAIDEN NAME unknown Marie				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. unknown		17. INFORMANT Records of Springfield State Hospital			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) --- DUE TO (c) ---							INTERVAL BETWEEN ONSET AND DEATH 4 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Sociopathic personality disturbance, drug addiction (morphine).							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) ---				
20c. TIME OF INJURY Hour a. m. --- p. m. ---	Month ---	Day ---	Year 49	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) ---	20f. (City or town) --- (County) --- (State) ---	
21. I certify that I attended the deceased from Jan. 7 , 19 57 , to Dec. 26 , 19 57 , that I last saw the deceased alive on December 26 , 19 57 , and that death occurred at 8:45 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Springfield State Hospital DATE SIGNED 12/27/57							
ACTUAL SIGNATURE Martin Gross			M.D. Springfield State Hospital				
PHYSICIAN'S NAME (Type) Martin Gross, M. D.			Sykesville, Maryland				
22a. BURIAL, CREMATION, REMOVAL (Specify) 12/30/57	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY Holy Redeemer Bldg		22d. LOCATION (City, town, or county) (State) Md			
23. FUNERAL DIRECTOR'S SIGNATURE Leonard J. Ruck			ADDRESS 5301 Hayford		24a. REC'D BY REGISTRAR DATE 12-27-57	24b. REGISTRAR'S SIGNATURE C. Harry Egan	

CERTIFICATE OF DEATH

<p>1. NAME OF DECEASED</p>		<p>2. SEX</p>		<p>3. AGE</p>		<p>4. DATE OF BIRTH</p>		<p>5. PLACE OF BIRTH</p>	
<p>6. OCCUPATION</p>		<p>7. MARITAL STATUS</p>		<p>8. CAUSE OF DEATH</p>		<p>9. MANNER OF DEATH</p>		<p>10. PLACE OF DEATH</p>	
<p>11. SIGNATURE OF DECEASED</p>		<p>12. SIGNATURE OF WITNESSES</p>		<p>13. SIGNATURE OF PHYSICIAN</p>		<p>14. SIGNATURE OF CORONER</p>		<p>15. SIGNATURE OF JUDGE</p>	

BUREAU V. B.

DEC 30 1957

RECEIVED

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12992

CERTIFICATE OF DEATH

12985

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Carroll			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural, Nr. Uniontown				c. LENGTH OF STAY IN 1b Life			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Union Bridge, Md. R.D.1 District				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Robert David Powell				4. DATE OF DEATH Month Dec. Day 11 Year 1957			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Aug. 6, 1877	
9. AGE (In years last birthday) 80 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer				10b. KIND OF BUSINESS OR INDUSTRY Farm		11. BIRTHPLACE (State or foreign country) Carroll Co., Md.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Ezra Powell				14. MOTHER'S MAIDEN NAME Mary Jane Reinecker			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No.		16. SOCIAL SECURITY NO. 218-10-2360A		17. INFORMANT Denton E. Powell Address Denton E. Powell, R.D.1, Union Bridge, Md.			
18. CAUSE OF DEATH {Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral hemorrhage DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arterio Sclerosis DUE TO (c)							
INTERVAL BETWEEN ONSET AND DEATH 6 days							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 12-5- , 19 57 , to 12-11- , 19 57 , that I last saw the deceased alive on 12-11- , 19 57 , and that death occurred at 4 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Union Bridge, Md. DATE SIGNED 12-12-57							
ACTUAL SIGNATURE T. H. Legg M.D.							
PHYSICIAN'S NAME (Type) T. H. Legg				Union Bridge, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/14/57		22c. NAME OF CEMETERY OR CREMATORY St. Marys Cemetery		22d. LOCATION (City, town, or county) (State) Silver Run, Carroll Co., Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Richard A. Little				ADDRESS Littlestown, Pa.		24a. REC'D BY REGISTRAR DATE DEC 13 '57	
				24b. REGISTRAR'S SIGNATURE W. H. Beach			

DEC 13 1957

John A. Baird

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 could be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the required information prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12993 CERTIFICATE OF DEATH

12986
Reg. Dist. No. 74

1. PLACE OF DEATH a. COUNTY <i>Cannell</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>MD</i> b. COUNTY <i>Baltimore</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Sykesville</i>				c. LENGTH OF STAY IN 1b <i>1 hour</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Holbrook 03 x 2.2</i>			
3. NAME OF DECEASED (Type or print) First <i>Lucy</i> Middle <i>VIRGINIA</i> Last <i>RANDALL</i>				4. DATE OF DEATH Month <i>Dec</i> Day <i>16</i> Year <i>1957</i>			
5. SEX <i>F.</i>		6. COLOR OR RACE <i>W</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>Oct. 8, 1874</i>	
9. AGE (In years last birthday) <i>83</i> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Floor Manager</i>				10b. KIND OF BUSINESS OR INDUSTRY <i>Clothing store</i>		11. BIRTHPLACE (State or foreign country) <i>MD</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>							
13. FATHER'S NAME <i>Wm. R. Randall</i>				14. MOTHER'S MAIDEN NAME <i>Ellen R. Stonfield</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>NO</i> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <i>212-03-4553</i>			
17. INFORMANT <i>Gilbert Randall - Sykesville, Md.</i>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary Arteriosclerosis</i> <i>420.1</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>pulmonary edema, Arteriosclerosis, anemia</i> DUE TO (c) <i></i> INTERVAL BETWEEN ONSET AND DEATH <i>Oct 57 to Dec 57</i>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i></i>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <i>Dec</i> 1957, to <i>Dec</i> 1957, that I last saw the deceased alive on <i>16 Dec</i> 1957, and that death occurred at <i>3:10 P. M.</i> from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>Howard E. Hall</i> M.D.				ADDRESS (Street, city or town, state) <i>Sykesville, Md</i> DATE SIGNED <i>16 Dec 57</i>			
PHYSICIAN'S NAME (Type) <i>HOWARD E. HALL</i>				SYKESVILLE, MD.			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <i>12-18-57</i>		22c. NAME OF CEMETERY OR CREMATORY <i>Woods Chapel</i>		22d. LOCATION (City, town, or county) (State) <i>Holbrook, Balt. Co., Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Arthur H. Haigh</i> ADDRESS <i>Sykesville, Md.</i>				24a. REC'D BY REGISTRAR DATE <i>12-17-57</i>		24b. REGISTRAR'S SIGNATURE <i>C. Harry Wace</i>	

CERTIFICATE OF DEATH

Date, Day, Mo.

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BUREAU V. S.

DEC 23 1957

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CERTIFICATE OF DEATH

Reg. Dist. No.

76

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Carroll			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) rural Smallwood				c. LENGTH OF STAY IN 1b life			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION R. F. D. 6				e. STREET ADDRESS 1 R. F. D. 6			
3. NAME OF DECEASED (Type or print) First William Middle Herman Last Riddle				4. DATE OF DEATH Month Dec. Day 9 Year 1957			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Feb. 18, 1908		9. AGE (In years last birthday) 49 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Shoe Factory		11. BIRTHPLACE (State or foreign country) Carroll County, Md.		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Daisy Riddle			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 217-01-7207		17. INFORMANT Address Miss Daisy Riddle Westminster, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 422.2 Myocarditis (Chr) IMMEDIATE CAUSE (a) Myocarditis (Chr) DUE TO Cardiac Arrest Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cardiac Arrest DUE TO Cardiac Arrest (c) Cardiac Arrest						INTERVAL BETWEEN ONSET AND DEATH 7-15-57 5 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 9, 1934 , to Aug 9, 1957 , that I last saw the deceased alive on Dec 17, 1957 , and that death occurred at 12:15 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE W.C. Jennings MD				ADDRESS (Street, city or town, state) 103 E. Main Westminster Md			
PHYSICIAN'S NAME (Type) W.C. Jennings MD				DATE SIGNED 12-10-57			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12-12-57		22c. NAME OF CEMETERY OR CREMATORY Deer Park Cemetery		22d. LOCATION (City, town, or county) (State) Smallwood, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE John R. Byers				ADDRESS Westminster, Maryland		24a. REC'D BY REGISTRAR Dec 12 1957	
				24b. REGISTRAR'S SIGNATURE Harriet Muller			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

12995 CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH o. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville				c. LENGTH OF STAY IN 1b 3 mo, 23 dys			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville				d. STREET ADDRESS 908 Viers Mills Road			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Mary Frances Honaman Russell				4. DATE OF DEATH Month Day Year December 6 1957			
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH November 19, 1883	9. AGE (In years last birthday) 74 yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Telephone operator			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Widd Bernard Minor Honeman			14. MOTHER'S MAIDEN NAME Sophia Berry				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no			16. SOCIAL SECURITY NO. unk		17. INFORMANT Springfield Hospital records		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) CBS associated with circulatory disturbance with cerebral arteriosclerosis, with psychotic reaction							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19			20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from August 13, 1957 , to December 6, 1957 , that I last saw the deceased alive on December 6, 1957 , and that death occurred at AM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Gertrud Sonnenfeldt M.D.			ADDRESS (Street, city or town, state) Springfield State Hospital Sykesville, Md.			DATE SIGNED 12/6/57	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/10/57		22c. NAME OF CEMETERY OR CREMATORY Rockville Cemetery		22d. LOCATION (City, town, or county) (State) Rockville, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey				ADDRESS Bethesda, Maryland		24a. REC'D BY REGISTRAR DEC 9 1957	
				24b. REGISTRAR'S SIGNATURE Harry Key			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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BUREAU V. S.

DEC 9 1957

RECEIVED

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admision) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN Ib	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore City 14 3Y01-4	
f. STREET ADDRESS 7000 Harford Avenue		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Dora Middle Hildebrand Last Schafer		4. DATE OF DEATH Month 12 Day 24 Year 19 57	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 17, 1869
9. AGE (In years last birthday) 88 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months 1 Days 1 Hours 1 Min. 1	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		11b. KIND OF BUSINESS OR INDUSTRY Home	
12. BIRTHPLACE (State or foreign country) Maryland		13. CITIZEN OF WHAT COUNTRY? USA	
14. FATHER'S NAME Charles Hildebrand		15. MOTHER'S MAIDEN NAME Mary	
16. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		17. SOCIAL SECURITY NO. 214-01-4395D	
18. INFORMANT Springfield Hospital records		Address	
19. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary Artery Disease DUE TO (c) Generalized Arteriosclerosis INTERVAL BETWEEN ONSET AND DEATH hours months years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) CBS associated with disturbance of metabolism, growth or nutrition, with senile brain disease, with psychotic reaction			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
21a. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		21b. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
22a. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		22b. (City or town) (County) (State)	
23. I certify that I attended the deceased from February 29, 56 , to 12 - 24 , 19 57 , that I last saw the deceased alive on 12 - 24 , 19 57 , and that death occurred at 1 P M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Springfield State Hospital DATE SIGNED Gertrud Sonnenfeldt			
ACTUAL SIGNATURE Gertrud Sonnenfeldt		M.D. Springfield State Hospital	
PHYSICIAN'S NAME (Type) Gertrud Sonnenfeldt, M.D.		Sykesville, Maryland	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE THEREOF Dec. 27, 1957	
24c. NAME OF CEMETERY OR CREMATORY Baltimore Cemetery		24d. LOCATION (City, town, or county) (State) Baltimore, Md.	
25. FUNERAL DIRECTOR'S SIGNATURE Ullrich Funeral Home 4210 Belair Road		25a. REC'D BY REGISTRAR DATE 12-25-57	
25b. REGISTRAR'S SIGNATURE C. Harry Shaw			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death; Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the register prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 12990
, 12997 Items 8,9 Film 223 12-12-57 et
CERTIFICATE OF DEATH

Reg. Dist. No. **74**

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville c. LENGTH OF STAY IN 1b 12 yrs. 2 mos. 14 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Essex, 0354.2 d. STREET ADDRESS 2 Wagners' Lane e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First John Middle Seibert Last Seibert 4. DATE OF DEATH Month December Day 9 Year 1957				5. SEX Male 6. COLOR OR RACE White 7. MARRIAGE NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH 1882 9. AGE (In years last birthday) 75 7/8 yrs. IF UNDER 1 YEAR: Months 7 Days 16 Hours 15 Min. 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Butcher 10b. KIND OF BUSINESS OR INDUSTRY Meat Company 11. BIRTHPLACE (State or foreign country) Maryland 12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Lawrence Seibert 14. MOTHER'S MAIDEN NAME Barbara Wills				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Not known (If yes, give war or dates of service) - 16. SOCIAL SECURITY NO. unk 17. INFORMANT Springfield Hospital Records Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriolosclerotic heart disease DUE TO 420.0 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 025x DUE TO General Paresis (c)						INTERVAL BETWEEN ONSET AND DEATH Years.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>July 1</u>, 19<u>50</u>, to <u>December 9</u>, 19<u>57</u>, that I last saw the deceased alive on <u>December 8</u>, 19<u>57</u>, and that death occurred at <u>8:30 A.M.</u>, from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>Walther H. Sonnenfeldt</i> M.D. ADDRESS (Street, city or town, state) Springfield State Hospital DATE SIGNED 12/9/57				PHYSICIAN'S NAME (Type) Walther H. Sonnenfeldt, M.D. Sykesville, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial 22b. DATE THEREOF 12-12-57 22c. NAME OF CEMETERY OR CREMATORY Western Cemetery 22d. LOCATION (City, town, or county) (State) Baltimore, Md.		23. FUNERAL DIRECTOR'S SIGNATURE <i>Wm. C. ...</i> ADDRESS 24a. REC'D BY REGISTRAR DATE 12-10-57 24b. REGISTRAR'S SIGNATURE <i>C. ...</i>					

Items 8,9: Notarized statement from daughter (filed)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the register prior to burial, cremation, or removal, and in any event within 72 hours after death.

DEC 11 1957

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12998 CERTIFICATE OF DEATH

12991

Reg. Dist. No. 16

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Patapsco</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>x2 Patapsco</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>-</u>		d. STREET ADDRESS <u>1</u>	
3. NAME OF DECEASED (Type or print) <u>DAVID</u> First <u>Edward</u> Middle <u>Shamer Sr</u> Last		4. DATE OF DEATH <u>December</u> Month <u>3</u> Day <u>1957</u> Year	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct 3. 1870</u>
9. AGE (In years last birthday) <u>87</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Conductor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Railroad</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>George L. Shamer</u>		14. MOTHER'S MAIDEN NAME <u>E. Jane Taylor</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>705-10-6497</u>	
17. INFORMANT <u>Evelyn I Shamer</u> Address <u>Patapsco Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic Myocarditis</u> 422.1 DUE TO <u>Arterio-Sclerotic Cardiovascular Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH _____			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____	
20c. TIME OF INJURY Month, Day, Year, Hour a. m. p. m. _____ 19 _____		20d. INJURY OCCURRED While _____ Not while _____ of work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <u>April 19</u> , 19 <u>54</u> , to <u>Dec 3</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Nov 29</u> , 19 <u>57</u> , and that death occurred at <u>11:40 A.M.</u> from the causes and on the date stated above. ACTUAL SIGNATURE <u>Joseph E. Bush</u> M.D. <u>Hampstead, Md.</u> DATE SIGNED <u>12-3-57</u> PHYSICIAN'S NAME (Type) <u>Joseph E. Bush MD</u> <u>HAMPSTEAD Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>12-7-57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>METHODIST GEM.</u>		22d. LOCATION (City, town, or county) <u>PATAPSCO</u> (State) <u>MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>David W. Bankard</u> ADDRESS <u>Westminster Md.</u>		24a. REC'D BY REGISTRAR <u>Dec 5, 1957</u>	
		24b. REGISTRAR'S SIGNATURE <u>Harriet Miller</u>	

BUREAU A. S.

DEC 6 1957

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12999 CERTIFICATE OF DEATH

12992

Reg. Dist. No. 74

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Balto. City	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN 1b 1 mo. 5 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital		d. STREET ADDRESS Baltimore 31.	
3. NAME OF DECEASED (Type or print) First John Middle SKUBER Last SKUBER		4. DATE OF DEATH Month December Day 5 Year 19 57	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 21, 1883
9. AGE (In years last birthday) 74 yrs.		IF UNDER 1 YEAR Months 74 Days 74 Hours 74 Min. 74	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Seaman		10b. KIND OF BUSINESS OR INDUSTRY Ymk -	
11. BIRTHPLACE (State or foreign country) Russia		12. CITIZEN OF WHAT COUNTRY? Russia	
13. FATHER'S NAME Peter Skuber		14. MOTHER'S MAIDEN NAME Ilsa Libek	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 086-12-8333	
17. INFORMANT Springfield Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic heart disease 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 002x (b) 002x DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Cerebral arteriosclerosis with psychosis. Pulmonary tuberculosis.			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 10/30/57 19 57 , to Dec. 5 , 19 57 , that I last saw the deceased alive on December 5 , 19 57 , and that death occurred at 11:10 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Springfield State Hospital DATE SIGNED 12/5/57 ACTUAL SIGNATURE Walther H. Sonnenfeldt M.D. PHYSICIAN'S NAME (Type) Walther H. Sonnenfeldt, M.D. Sykesville, Maryland.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Dec. 10, 1957	
22c. NAME OF CEMETERY OR CREMATORY Sacred Heart		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Lilly & Zeiler Inc., 403 S. Wolfe Street		24a. REC'D BY REGISTRAR DATE 12-8-57	
24b. REGISTRAR'S SIGNATURE C. H. H. H.			

CERTIFICATE OF DEATH

1957

Page 100

BUREAU V. S.

DEC 10 1957

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
BM 2/57

13000

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12993

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Carroll</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>MD</i> b. COUNTY <i>Carroll</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rural Manchester #1</i>		c. LENGTH OF STAY IN lb <i>40 yrs</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Manchester RD #1</i>		d. STREET ADDRESS <i>Manchester RD #1</i>	
3. NAME OF DECEASED (Type or print) <i>CURTIS STAMBAUGH</i>		4. DATE OF DEATH <i>Dec 7 1957</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Aug. 30, 1890</i>
9. AGE (In years last birthday) <i>67 yrs.</i>		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Labour</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Feed Co.</i>	
11. BIRTHPLACE (State or foreign country) <i>Pa</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A</i>	
13. FATHER'S NAME <i>William Stambaugh</i>		14. MOTHER'S MAIDEN NAME <i>Elizabeth Stauffer</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, unknown) <i>unknown</i>		16. SOCIAL SECURITY NO. <i>214-16-1066</i>	
17. INFORMANT <i>Miss William Ingreham-Westminster, Md.</i>		Address <i>R.D. 7</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>GUNSHOT WOUND OF HEAD</i> <i>976x</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)			INTERVAL BETWEEN ONSET AND DEATH <i>7 min.</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>Gunshot wound of head - self inflicted</i>	
20c. TIME OF INJURY Month, Day, Year <i>8:30 a.m. 12-7-57</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Home</i>	20f. (City or town) (County) (State) <i>RI Manchester Carroll Md</i>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>James J. Marsh</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <i>JAMES T. MARSH</i>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>12/10/57</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Black Oak Church</i>		22d. LOCATION (City, town, or county) (State) <i>Black Oak York Pa</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>H. Seifert</i>		ADDRESS <i>Black Oak, Pa.</i>	
24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE <i>Wm. H. Perry</i>	
DATE <i>DEC 11 1957</i>			

DATE SIGNED
12-7-57

STATE OF NEW YORK
DEPARTMENT OF HEALTH

NEW YORK STATE DEPARTMENT OF HEALTH - BATHING
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. S.

DEC 11 1951

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13001

CERTIFICATE OF DEATH

Reg. Dist. No.

76

1. PLACE OF DEATH a. COUNTY <u>CARROLL</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>M.D.</u> b. COUNTY <u>CARROLL</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL WESTMINSTER</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>27 WESTMINSTER</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>94 COUNTRY HOME</u>		d. STREET ADDRESS <u>1 WIMBERT AVE.</u>	
3. NAME OF DECEASED (Type or print) <u>JOHN</u> First <u>HARVEY</u> Middle <u>STORMS</u> Last		4. DATE OF DEATH <u>DEC</u> Month <u>6</u> Day <u>1957</u> Year	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>APR 4 1873</u>
9. AGE (In years last birthday) <u>84</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED B+O Rwy Engineer + State Rde. Employee</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>M.D.</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13. FATHER'S NAME <u>Not known</u>		14. MOTHER'S MAIDEN NAME <u>Not known</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>MINNIE V. FRANKLIN BALTO. M.D.</u>		Address <u>1304 JAMES ST.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Decompensation</u> <u>421.4</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <u>Talculular lesions</u> DUE TO (c) <u>?</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 mo</u> <u>7 years (2)</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>X</u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>X</u> 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>X</u>		20f. (City or town) <u>X</u> (County) <u>X</u> (State) <u>X</u>	
21. I certify that I attended the deceased from <u>11-1-</u> , 19 <u>57</u> , to <u>12-6-</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>12-6-</u> , 19 <u>57</u> , and that death occurred at <u>M</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>W. E. Storer</u>		ADDRESS (Street, city or town, state) <u>1215 5th Street Md</u> DATE SIGNED <u>12-7-57</u>	
PHYSICIAN'S NAME (Type) <u>W. E. Storer</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>12-8-1957</u>	22c. NAME OF CEMETERY OR CREMATORY <u>METHODIST CEMETERY</u>	22d. LOCATION (City, town, or county) (State) <u>UNIONTOWN M.D.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>David G. Bankard Westminster Md.</u>		24a. REC'D BY REGISTRAR <u>DATE 12-7-57</u> 24b. REGISTRAR'S SIGNATURE <u>Harriet Miller</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registration prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH-BALTIMORE 18

BUREAU V. S.

DEC 11 1957

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

-13002 CERTIFICATE OF DEATH

1299574
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Balto. City			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville				c. LENGTH OF STAY IN 1b 20yrs. 2mos. 10 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital				d. STREET ADDRESS 2918 Cresmont Ave.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Louisa Middle Wolbrach Last SUDSBURG				4. DATE OF DEATH Month December Day 14 Year 1957			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH August 11, 1867	
9. AGE (In years last birthday) 90 yrs.		IF UNDER 1 YEAR Months 3 Days 01 Hours 4 Min.		IF UNDER 24 HRS. Months 0 Days 0 Hours 0 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (State or foreign country) Germany	
12. CITIZEN OF WHAT COUNTRY? Unknown							
13. FATHER'S NAME Ludwig Wolbrach				14. MOTHER'S MAIDEN NAME Fredrica Rommel			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. -		17. INFORMANT Springfield Hospital Records	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic heart disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Paranoid condition				INTERVAL BETWEEN ONSET AND DEATH 3 days Years			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from July 1, 1950 , to December 14, 1957 , that I last saw the deceased alive on December 14, 1957 , and that death occurred at 2:40 P.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE Walther H. Sonnenfeldt M.D.				ADDRESS (Street, city or town, state) Springfield State Hospital			
DATE SIGNED 12/15/57							
PHYSICIAN'S NAME (Type) Walther H. Sonnenfeldt, M.D.				Sykesville, Maryland.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/18/57		22c. NAME OF CEMETERY OR CREMATORY New Cathedral Cem.		22d. LOCATION (City, town, or county) (State) Balto., Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Lickner & Sons - Balto.				ADDRESS 17th		24a. REC'D BY REGISTRAR DEC 18 1957	
24b. REGISTRAR'S SIGNATURE C. Harry Heys							

RECEIVED

DEC 18 1957

BUREAU V. S.

MARLAND STATE DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS	
CERTIFICATE OF DEATH	
See Page 10	
1. NAME OF DECEASED	
2. SEX	
3. AGE	
4. DATE OF BIRTH	
5. PLACE OF BIRTH	
6. OCCUPATION	
7. CAUSE OF DEATH	
8. PLACE OF DEATH	
9. DATE OF DEATH	
10. SIGNATURE OF DECEASED	
11. SIGNATURE OF WITNESS	
12. SIGNATURE OF DECEASED	
13. SIGNATURE OF WITNESS	
14. SIGNATURE OF DECEASED	
15. SIGNATURE OF WITNESS	
16. SIGNATURE OF DECEASED	
17. SIGNATURE OF WITNESS	
18. SIGNATURE OF DECEASED	
19. SIGNATURE OF WITNESS	
20. SIGNATURE OF DECEASED	
21. SIGNATURE OF WITNESS	
22. SIGNATURE OF DECEASED	
23. SIGNATURE OF WITNESS	
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27. SIGNATURE OF WITNESS	
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31. SIGNATURE OF WITNESS	
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

13003
 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 1812996
 CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Carroll</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural-Sykesville</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural-Sykesville</u>			
c. LENGTH OF STAY IN 1b <u>Life</u>				d. STREET ADDRESS <u>Oakland Road</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Oakland Road</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Norwood</u> Middle <u>Vernon</u> Last <u>Prott</u>				4. DATE OF DEATH Month <u>Dec.</u> Day <u>28</u> Year <u>1957</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Feb. 3, 1887</u>	
9. AGE (In years last birthday) <u>70</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Real Estate</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Property & Homes</u>		11. BIRTHPLACE (State or foreign country) <u>Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Wm. H. Prott</u>				14. MOTHER'S MAIDEN NAME <u>Mary N. Conway</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) <u>-</u>				16. SOCIAL SECURITY NO. <u>217-07-2343</u>		17. INFORMANT Address <u>Mrs. Marie A. Prott-Sykesville, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Generalized carcinomatosis</u> <u>177x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>adenocarcinoma of prostate</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <u>2-3 wks</u> <u>4-6 mos.</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____							
21. I certify that I attended the deceased from <u>1935</u> , 19____, to <u>December 28, 1957</u> , that I last saw the deceased alive on <u>December 28, 1957</u> , and that death occurred at <u>11:55 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Liberty Road at Eldersburg</u> DATE SIGNED <u>12.28.57</u> ACTUAL SIGNATURE <u>W. H. Lawson</u> M.D. _____ PHYSICIAN'S NAME (Type) <u>Wm. H. Lawson, Jr., M.D.</u> <u>Sykesville P.O., Maryland</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1-1-58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>New Oakland</u>		22d. LOCATION (City, town, or county) (State) <u>Near Sykesville, Carroll Co. Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur E. Wright</u> ADDRESS <u>Sykesville, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>12-31-57</u>		24b. REGISTRAR'S SIGNATURE <u>C. Harry Allen</u>	

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, MD.

BUREAU V. S.

JAN 6 1953

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12997

12943

CERTIFICATE OF DEATH

Reg. Dist. No.

76

1. PLACE OF DEATH a. COUNTY CARROLL MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY CARROLL			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WESTMINSTER				c. LENGTH OF STAY IN 1b 46 yrs			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 115 W. MAIN ST.				e. STREET ADDRESS 115 W. MAIN ST.			
3. NAME OF DECEASED (Type or print) CHARLES John VELNOSKEY				4. DATE OF DEATH DEC. 21 1957			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 8, 1880		9. AGE (In years last birthday) 77 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Shoe-maker				10b. KIND OF BUSINESS OR INDUSTRY repairing		11. BIRTHPLACE (State or foreign country) Baltimore	
12. CITIZEN OF WHAT COUNTRY? U. S. A.				13. FATHER'S NAME Charles K. Velnoskey			
14. MOTHER'S MAIDEN NAME Marg				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO. 219-32-1834				17. INFORMANT Mrs. Charles J. Velnoskey, Westminister, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma Prostate Cerebral Metastasis 177X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				INTERVAL BETWEEN ONSET AND DEATH 4 yrs.			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.			
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)				21. I certify that I attended the deceased from 10/17 , 19 49 , to 12/21 , 19 57 , that I last saw the deceased alive on 12/21 , 19 57 , and that death occurred at 11 P. M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE G. Allen Moulton				ADDRESS (Street, city or town, state) 148 W. MAIN ST. Westminister, Md.			
PHYSICIAN'S NAME (Type) G. ALLEN MOULTON, M.D.				DATE SIGNED 12/21/57			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 12/24/57			
22c. NAME OF CEMETERY OR CREMATORY Westminister Cemetery				22d. LOCATION (City, town, or county) (State) Westminister, Md.			
23. FUNERAL DIRECTOR'S SIGNATURE J. E. Myers, Jr. Westminister, Md.				24a. REC'D BY REGISTRAR DATE DEC 23, 1957			
24b. REGISTRAR'S SIGNATURE H. Ernest Miller							

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, MD.

RECEIVED

DEC 27 1967

BUREAU V. 2

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the required information prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12998

13004

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Carroll b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Taneytown		MARYLAND c. LENGTH OF STAY IN 1b 2 years		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Carroll c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X2 Taneytown		d. STREET ADDRESS 1 Middle Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First John Middle Robert Last Wright				4. DATE OF DEATH Month December Day 8 Year 19 57									
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH February 5, 1881		9. AGE (In years last birthday) 76 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer				10b. KIND OF BUSINESS OR INDUSTRY Own Farm		11. BIRTHPLACE (State or foreign country) Maryland				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Samuel P. Wright						14. MOTHER'S MAIDEN NAME Margaret Fawley Wright							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT Address Miss Clara Stunkle, Taneytown, Maryland							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Heart Disease 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 360X (b) Generalized Arteriosclerosis DUE TO (c)										INTERVAL BETWEEN ONSET AND DEATH 5 yrs 5-10 yrs.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Adenocarcinoma of Rectum, Diabetic Mellitus												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that I attended the deceased from 12/5 , 19 56 , to 12/8 , 19 57 , that I last saw the deceased alive on 11/27 , 19 57 , and that death occurred at 1 A. M, from the causes and on the date stated above.													
ACTUAL SIGNATURE R. S. McVaugh				ADDRESS (Street, city or town, state) 49 Frederick St. Taneytown, Md.				DATE SIGNED 12/8/57					
PHYSICIAN'S NAME (Type) R. S. McVaugh													
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 12/10/57		22c. NAME OF CEMETERY OR CREMATORY Monocacy Cemetery		22d. LOCATION (City, town, or county) Beallsville, Maryland		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE C. O. Fuss & Son						ADDRESS Taneytown, Maryland		24a. REC'D BY REGISTRAR DATE DEC 11 '57		24b. REGISTRAR'S SIGNATURE W. L. Smith			

CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH		CITY		STATE		COUNTRY	
JAMES H. HARRIS		Male		45		1912		Baltimore		Maryland		United States		United States	
OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH		DATE OF DEATH		PLACE OF DEATH		CITY		STATE		COUNTRY	
Salesman		Heart Disease		Natural		1957		Baltimore		Maryland		United States		United States	
Physician		Hospital		Date		Time		Signature		Title		Institution		City	
J. H. Harris		St. Mary's Hospital		12/10/57		10:30 AM		J. H. Harris		Physician		St. Mary's Hospital		Baltimore	

RECEIVED
DEC 11 1957
BUREAU V. S.

RECEIVED

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
13005 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12999

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Taneytown -Rural</u>		c. LENGTH OF STAY IN 1b <u>40yrs</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. STREET ADDRESS <u>X/ Rural Taneytown</u>	
3. NAME OF DECEASED (Type or print) First <u>Maude</u> Middle <u>L.</u> Last <u>Zimmerman</u>		4. DATE OF DEATH Month <u>December</u> Day <u>14</u> Year <u>1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 3. 1884</u>
9. AGE (In years last birthday) <u>73</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Charles Phillips</u>		14. MOTHER'S MAIDEN NAME <u>Ida R. Nusbaum</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u> </u>	
17. INFORMANT <u>Mr. Luther A. Zimmerman, Taneytown, Maryland</u>		Address <u> </u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY Occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u> </u> (a), stating the underlying cause last. DUE TO (c) <u> </u>			INTERVAL BETWEEN ONSET AND DEATH <u>min</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> a. m. <u> </u> p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>James T. Marsh</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>JAMES T. MARSH</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12/17/57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Baust Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Tyrone, Carroll Co., Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>C.O. Fuss & Son, Taneytown, Maryland</u>		24a. REC'D BY REGISTRAR <u> </u> 24b. REGISTRAR'S SIGNATURE <u> </u>	
DATE <u>DEC 18 '57</u>			

MEDICAL CERTIFICATION

18002 MEDICAL EXAMINER'S CERTIFICATE OF DEATH
MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10

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BUREAU V. S.

DEC 18 1957

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